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	495394	A. BUILDING _____ B. WING _____	C 06/22/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LAURELS OF BON AIR	9101 BON AIR CROSSINGS DRIVE BON AIR, VA 23235

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 06/19/18 through 06/22/18. Corrections are required for compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities. One complaint was investigated during the survey.	E 000		
E 026 SS=C	Roles Under a Waiver Declared by Secretary CFR(s): 483.73(b)(8) [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. At a minimum, the policies and procedures must address the following:] (8) [(6), (6)(C)(iv), (7), or (9)] The role of the [facility] under a waiver declared by the Secretary, in accordance with section 1135 of the Act, in the provision of care and treatment at an alternate care site identified by emergency management officials. *[For RNHCIs at §403.748(b):] Policies and procedures. (8) The role of the RNHCI under a waiver declared by the Secretary, in accordance with section 1135 of Act, in the provision of care at an alternative care site identified by emergency management officials. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review it was determined that the facility staff	E 026	The Laurels of Bon Air wishes to have this submitted plan of correction stand as	8/3/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 07/13/2018

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E 026	Continued From page 1 failed to have a complete emergency preparedness plan. The facility staff failed to develop policies and procedures in the emergency plan that describe the facility's role in providing care and treatment at altered care sites under an 1135 waiver. The findings include: On 06/21/18 at 3:00 p.m. a review and interview of the facility's emergency preparedness plan was conducted with ASM (administrative staff member) # 1, the administrator. Review of the facility's emergency preparedness plan failed to evidence policies and procedures in the emergency plan that describe the facility's role in providing care and treatment at altered care sites under an 1135 waiver. ASM # 1 stated he would look for it. On 06/22/18 at approximately 8:00 a.m., ASM # 1 provided this survey with a document entitled "Providing Care and Treatment at an Alternate Care Site under 1153 Waiver." ASM # 1 stated that the document was put together the evening before. On 06/22/18 at approximately 12:00 p.m., ASM (administrative staff member) # 1, administrator, ASM # 2, director of nursing were made aware of the above findings. No further information was provided prior to exit.	E 026	its allegation of compliance. Our date of alleged compliance is August 3, 2018. Preparation and/or execution of this plan of correction does not constitute admission to, nor agreement with, either the existence of or the scope and severity of any of the cited deficiencies, or conclusions set forth in the statement of deficiencies. This plan is prepared and/or executed to ensure continuing compliance with regulatory requirements. A description of the facility's role in providing care and treatment at an alternate care site under the 1135 waiver has been written. All residents have the potential to be affected. The Administrator will be educated on the regulation requiring a description of how the facility will provide care at an alternate care site under an 1135 waiver. The Administrator has audited the Emergency Preparedness Plans and has updated the plan with the written description of the facility's role under an 1135 waiver. Continued compliance will be monitored through the facility's quality assurance program. Additional education and monitoring will be initiated for any identified concerns.	
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid survey was conducted from 6/19/18 through 6/22/18.	F 000		

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F 000	Continued From page 2 Corrections are required for compliance with the following 42 CFR Part 483 of the Federal Long Term Care requirements. The life safety code survey/report will follow. One complaint was investigated during survey. The census at this 124 certified bed facility was 112 at the time of the survey. The survey sample consisted of 28 current residents, (Residents # 94, 109A, 108, 43, 32, 309, 1, 102, 158, 311, 37, 81, 64, 308, 22, 23, 51, 6, 20, 9, 46, 67, 50, 39, 105, 59, 74, and 312; and four closed records, Residents #2, 110, 109B, and 76.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source.	F 550		8/3/18

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F 550	Continued From page 3 §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview and facility document review, it was determined that the facility staff failed to maintain a resident's dignity during incontinence care for one of 32 residents in the survey sample, Resident # 32. The facility staff failed to keep Resident # 32 covered during incontinence care. The findings included: Resident # 32 was admitted to the facility on 08/12/16 with diagnoses that included but were not limited to Alzheimer's disease (1), anxiety (2), and dysphagia (3). On 06/19/18 at approximately 6:30 p.m., during the initial tour of the facility an observation of Resident # 32's and Resident # 32's room was	F 550	Resident #32 suffered no adverse effects and did not require transfer to a higher level of care. Resident #32 is receiving incontinence care daily and protocols for dignity are being followed. A quality review of current residents receiving incontinence care has been performed. Licensed Nursing Staff re-educated by DON/Designee regarding ensuring that privacy curtains are used when providing care to residents. DON/Designee to conduct quality monitoring for the use of privacy curtains during resident care five times a week x1, weekly x4 weeks and then monthly, PRN and as indicated.	

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conducted. During the tour Resident # 32's room door was closed. When this surveyor knocked on the door, staff inside the room stated to come in. Upon entering the room and standing just inside the room, Resident # 32 was observed on the B-side of the room, next to the window, the privacy curtain between the A-side and B-side beds was pulled approximately one-third away from the wall exposing Resident # 32 from her waist to her feet. Further observation revealed Resident # 32 was uncovered from her waist to her feet exposing the brief Resident # 32 was wearing. Resident # 32's roommate and visitor were present in the room at the time of the observation on the A-side of the room. They were observed crowded behind the partially closed privacy curtain.

Resident # 32's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 04/19/18, coded Resident # 32 as scoring a 0 (zero) on the brief interview for mental status (BIMS) of a score of 0 - 15, 0 (zero) - being severely impaired of cognition for making daily decisions. Resident # 32 was coded as requiring extensive assistance of one staff member for activities of daily living.

On 06/22/18 at 8:20 a.m., an interview was conducted with CNA (certified nursing assistant) # 1. When asked to describe the procedure for maintaining a resident's dignity while providing incontinence care to a resident CNA # 1 stated, "During care I keep the area of the resident's body I'm working on covered with a sheet or the gown if they are wearing one." When asked how the reasonable person would feel if they were exposed like, Resident # 32 was observed when receiving personal/incontinence care, CNA # 1

Findings to be communicated to the QA committee monthly and as indicated. Quality monitoring schedules will be modified as indicated based on findings.

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F 550	Continued From page 5	F 550		

stated, "They wouldn't feel comfortable because no one would want to be exposed to someone who is not taking care of them and their sense of modesty would be violated."

Attempts were made during the days of the survey to interview Resident # 32's roommate and visitor who was present during the observation of Resident # 32 on 06/19/18. The attempts were unsuccessful due to the unavailability of Resident # 32's roommate and visitor.

The facility's "Resident Rights & Facility Responsibilities" documented, "(a) Residents Rights. The resident has a right to a dignified existence, self resident's self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. (1) Dignity, Respect & Quality of Life. A facility must treat each resident with respect and dignity and care for each resident in a manner an in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident."

On 06/22/18 at approximately 12:00 p.m., ASM (administrative staff member) # 1, administrator, ASM # 2, director of nursing were made aware of the above findings.

No further information was provided prior to exit.

References:
(1) A brain disorder that seriously affects a person's ability to carry out daily activities). This

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F 550	Continued From page 6 information was obtained from the website: https://www.nlm.nih.gov/medlineplus/alzheimersdisease.html. (2) Fear. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/anxiety.html#summary. (3) A swallowing disorder. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/swallowingdisorders.html.	F 550		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that	F 580		8/3/18

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F 580	Continued From page 7 all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, facility document review and clinical record review, it was determined the facility staff failed to notify the physician and/or the nurse practitioner and/or resident representative of a change in condition for three of 32 residents in the survey sample, Residents #23, #311 and #50. 1. The facility staff failed to notify Resident #23's physician and/or nurse practitioner of Resident #23's noncompliance with her 1200 cc (cubic centimeter) per 24 hours fluid restriction on	F 580	The Physician has been notified of resident #23s non-compliance of her 1200cc per 24 hours fluid restriction. Resident #311 did not require transfer to a higher level of care and did not sustain any adverse effects. The Physician has been notified of resident #50s transfer to a higher level of care following blood sugar of 50. A quality review of residents with physician orders for fluid restrictions has	

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F 580	Continued From page 8 6/2/18, 6/4/18, and 6/14/18. 2. The facility staff failed to notify the physician that Resident #311's medications were not available for administration. 3. The facility staff failed to notify the physician when Resident #50's blood sugar reading was 50. The findings include: 1. The facility staff failed to notify Resident #23's physician and/or nurse practitioner of Resident #23's noncompliance with her 1200 cc (cubic centimeter) per 24 hours fluid restriction on 6/2/18, 6/4/18, and 6/14/18. Resident #23 was admitted to the facility on 2/28/18, with diagnoses that included but were not limited to: heart disease, high blood pressure, hyponatremia (Low sodium level in the blood) (1), bipolar disorder (a mental illness which includes unusual mood changes) (2), and muscle weakness. The most recent MDS (minimum data set) assessment, a quarterly assessment, with an ARD (assessment reference date) of 4/4/18, coded the resident as scoring a 15 on the BIMS (brief interview for mental status) score, indicating that she had no cognitive impairment. She was coded as always understanding others and always making herself understood. Resident #23 was coded as requiring extensive assistance of one or more staff members for bed mobility, transfers, toileting, and personal hygiene. A review of the comprehensive care plan dated 3/5/18, with a most recent revision on 3/12/18,	F 580	been performed. A quality review of residents in the facility has been performed for medication administration and documentation. A quality review of residents with orders for accu-checks has been performed. Licensed Nurses will be educated by DON/Designee regarding notifying the Physician of medications not administered, resident non-compliance for fluid restrictions and abnormal blood sugars. DON/Designee during morning clinical meeting to conduct quality monitoring of Physician notification of abnormal blood sugars, resident non-compliance with fluid restriction and medications not administered, 5x week x1 weeks, weekly x4 weeks and then monthly and PRN and as indicated. Findings to be communicated to the QA committee monthly and as indicated. Quality monitoring schedules modified based on findings.	

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documented in part, "Need: At nutritional risk and/or dehydration R/T (related to): decreased appetite ...hyponatremia, diuretic use and fluid restriction." In the Interventions section of this need it is documented in part, "Follow fluid restrictions as ordered."

A physician's order with a start date 3/6/18 documented an order of 1200 cc QD (every day) every 24 hours 1200cc fluid restriction. This order does not have a discontinuation date.

A nurse practitioner note dated 6/20/18 documented in part: "Pertinent labs (laboratory tests): [sodium] 136 [normal range for blood sodium levels is 135 to 145 milliequivalents per liter (mEq/L) (3)] ...hyponatremia ongoing, continue fluid restriction."

A review of Resident #23's fluid intake report documents that Resident #23 exceeded the ordered fluid amount on 6/2/18 with a fluid intake of 1600 cc, on 6/4/18 with a fluid intake of 1400 cc, and on 6/14/18 with a fluid intake of 1540 cc. A review of the nurse's notes from 6/1/18 to 6/20/18 failed to document that the staff notified either the physician or nurse practitioner that Resident #23's exceeded the prescribed fluid amount on these dates.

On 6/20/18 at 08:58 a.m., an interview was conducted with Resident #23. When asked if she was aware of a physician's order restricting her fluid intake, Resident #23 stated "Yes." When asked about the numerous unopened soda cans on her bedside table, Resident #23 stated, "They told me I could drink as many of those as I wanted because they [the sodas] don't count."

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When asked who told her this, Resident #23 responded, "The staff."

An interview was conducted on 6/21/18 at 2:20 p.m. with CNA (certified nursing assistant) #4. CNA #4 was asked exactly what fluids are recorded on the daily intake report. CNA #4 stated the fluids from the resident's food trays and any amount the nurses give the resident with medications. When asked if she communicated the daily fluid intakes to the nurses, CNA #4 stated "Yes, we tell the nurses the amount, then they tell us the amount from medications, and it is added together into the report." CNA #4 was shown the June intake report for Resident #23 and was asked about the days where the fluid restriction was exceeded. CNA #4 stated, "The resident sneaks sodas." When asked if this was communicated to the nurses, CNA #4 stated "Yes."

On 6/21/18 at 2:25 p.m., an interview was conducted with LPN (licensed practical nurse) #7. LPN #7 confirmed that the nursing staff communicate with each other and that she lets the CNAs know how much fluid the resident receives when taking their medication. When asked what nursing does when the resident has exceeded the daily limit, LPN #7 stated they document it. When asked if they alert the physician or nurse practitioner LPN #7 stated "Usually but [Resident #23's name] has been noncompliant with her fluid restriction many times." When asked if the noncompliance was documented or reported, LPN #7 stated she did not know.

Review of the June 2018 nurse's notes did not evidence documentation regarding the resident's

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non-compliance with the fluid restriction.

On 6/22/18 at 11:08 a.m., an interview was conducted with ASM (administrative staff member) #3, the nurse practitioner. ASM #3 was asked if she or the physician should be contacted when fluid restrictions are exceeded. ASM #3 stated "Yes." ASM #3 was shown the daily fluid intake report for June 2018. She stated that she was unaware of the exceeded fluid intakes for Resident #23 on 6/2/18, 6/4/18 and 6/14/18; however, she did acknowledge that Resident #23 was known to be occasionally noncompliant with her ordered care.

ASM #1 (the administrator), ASM #2, (the director of nursing), ASM #4, (the regional director of operations), and ASM #5 (the regional clinical coordinator) were made aware of the above concern on 6/22/18 at 12:02 p.m.

No further information was provided prior to exit.

(1) This information was obtained from the following website:
https://medlineplus.gov/ency/article/000394.htm
(2) This information was obtained from the following website:
https://medlineplus.gov/bipolardisorder.html
(3) This information was obtained from the following website:
https://medlineplus.gov/ency/article/003481.htm

2. The facility staff failed to notify the physician that Resident #311's medications were not available for administration.

Resident #311 was admitted to the facility on

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6/8/18 with diagnoses that included but were not limited to: infection of the hip, heart failure, irregular heart beat, diabetes, high blood pressure and urinary tract infection.

The most recent MDS (minimum data set) an admission assessment with an ARD (assessment reference date) of 6/15/18 coded the resident as having scored a 12 out of 15 on the brief interview for mental status, indicating the resident was moderately impaired to make daily decisions.

Review of the resident's care plan initiated on 6/21/18 documented, "Focus. CARDIAC: At risk for decreased Cardiac Output R/T (related to): HTN (hypertension), A-Fib (atrial fibrillation -- an irregular heartbeat), and CHF (congestive heart failure). Interventions. Administer medications as ordered. "

Review of the physicians orders dated 6/8/18 documented, "Amiodarone HCL (1) Tablet 200 MG (milligrams). Give 1 tablet by mouth one time a day for AFIB (atrial fibrillation -- an irregular heartbeat). Start Date: 06/09/2018. Metoprolol Succinate XL (2) Give 100 mg by mouth one time a day for HTN (hypertension). Start Date: 06/09/2018. Keppra (3) Give 500 mg by mouth two times a day for Seizures. Start Date: 06/09/2018. Midrodine (4) 5 mg Give by mouth. Start Date: 06/09/2018. Oxybutynin (5) 2.5 mg give by mouth. Start Date: 06/09/2018. Spironolactone (6) 25 mg Give 1 tablet by mouth one time a day for Heart Failure. Start Date 06/08/2018."

Review of the June 2018 MAR (medication administration record) documented:

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"Amiodarone HCL Tablet 200 MG (milligrams). Give 1 tablet by mouth one time a day for AFIB (atrial fibrillation -- an irregular heartbeat). Start Date: 06/09/2018." On 6/9/18, a "5" and the nurse's initials were documented.

"Metoprolol Succinate XL. Give 100 mg by mouth one time a day for HTN (hypertension). Start Date: 06/09/2018. "On 6/9/18 a "5" and the nurse's initials were documented.

"Keppra Give 500 mg by mouth two times a day for Seizures. Start Date: 06/09/2018." On 6/9/18, a "5" and the nurse's initials were documented at 9:00 a.m. and 5:00 p.m.

"Midrodine 5 mg Give by mouth. Start Date: 06/09/2018." On 6/918 at 9:00 a.m., 1:00 p.m. and 8:00 p.m. and on 6/10/18 at 9:00 a.m. and 1:00 p.m. a "5" and the nurse's initials were documented.

"Oxybutynin 2.5 mg give by mouth. Start Date: 06/09/2018." On 6/9/18 at 9:00 a.m. and 5:00 p.m. and on 6/10/18 at 9:00 a.m. and 5:00 p.m. a "5" and the nurse's initials were documented.

"Spironolactone 25 mg Give 1 tablet by mouth one time a day for Heart Failure. Start Date 06/08/2018." On 6/9 and 6/10/18 at 9:00 a.m., a "5" and the nurse's initials were documented.

Review of the chart codes on the MAR documented, "5= Hold/See Nurses Notes."

Review of the nurse's notes documented: "6/9/2018 15:10 (3:10 p.m.) eMar (electronic medication administration record) - Medication Administration Note. Amiodarone HCL

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(hydrochloride) Tablet 200 MG Give 1 tablet by mouth one time a day for AFIB. Awaiting pharmacy;

6/9/18 15:13 (3:13 p.m.) eMAR - Medication Administration Note. Metoprolol Succinate XL. Give 100 mg by mouth one time a day for HTN. Awaiting pharmacy;

6/9/18 15:13 eMar (electronic medication administration record) - Medication Administration Note. Metoprolol Succinate XL. Give 100 mg by mouth one time a day for HTN. Awaiting pharmacy;

6/9/18 15:13 eMar (electronic medication administration record) - Medication Administration Note. Midrodine 5mg Give by mouth. Awaiting pharmacy;

6/9/18 15:14 eMar (electronic medication administration record) - Medication Administration Note. Oxybutynin 2.5 mg Give by mouth. Awaiting Pharmacy;

6/9/18 15:14 eMar (electronic medication administration record) - Medication Administration Note. Spironolactone 25 mg Give 1 tablet by mouth one time a day for Heart Failure. Awaiting pharmacy. "

There was no evidence of documentation that the physician had been notified.

An interview was conducted on 6/22/18 at 9:17 a.m. with LPN (licensed practical nurse) #1, the nurse who documented the medications as unavailable. When asked how medications are obtained for new admissions, LPN #1 stated, "So,

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when I get the admission when the order is put in, it [medications] comes in that night." When asked what staff did if a resident's medications were not available, LPN #1 stated, "I usually call the pharmacy. I can't remember if I called them that night." When asked if anyone else would be notified, LPN #1 stated, "No."

An interview was conducted on 6/22/18 at 9:19 a.m. with RN (registered nurse) #1, the unit manager. When asked about the process staff follows if a resident's medications are not available, RN #1 stated, "They notify the doctor."

An interview was conducted on 6/22/18 at 9:53 a.m. with LPN #2. When asked what process staff follows if the medications ordered were not available, LPN #2 stated, "If its not in the (name of medication dispensing machine) I have to call the doctor and see if he wants to change the order or hold it for today and start it the next day."

On 6/22/18 at 12:10 a.m. ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing were made aware of the findings.

Review of the facility's policy titled, "PHYSICIAN NOTIFICATION" documented, "Policy: The licensed nurse will report changes in the guest's condition due to illness, exacerbation of existing condition, or accidents and incidents to the physician, nurse practitioner, or physician assistant, following the established Interact protocols for immediate, not-immediate, or routing notification. Definitions: Immediate: Notify the attending or on-call MD (medical doctor), NP (nurse practitioner), or PA (physician's assistant) as soon as possible. Non-Immediate: Notify the

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attending or on-call MD, NO (sic), or PA no later than the next work day. Routine: Notify the attending or on-call MD, NP, or PA no later than the next regular visit...Procedure: 1. Notify the physician of a change in the guest's condition. 2. Document the time and date that the physician was notified, the physician's response, and any treatment ordered in the Progress Notes."

No further information was obtained prior to exit.

1. Amiodarone is a potent arrhythmia suppressing agent that has been clearly linked to several distinct forms of drug induced liver disease. This information was obtained from: https://livertox.nih.gov/Amiodarone.htm

2. Metoprolol is a cardioselective beta-blocker that is widely used in the treatment of hypertension and angina pectoris. Metoprolol has been linked to rare cases of drug induced liver injury. This information was obtained from: https://livertox.nih.gov/Metoprolol.htm

3. KEPPRA is indicated as adjunctive therapy in the treatment of partial onset seizures in adults and children 1 month of age and older with epilepsy. This information was obtained from: https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=3ca9df05-a506-4ec8-a4fe-320f1219ab21

4. Midodrine hydrochloride tablets are indicated for the treatment of symptomatic orthostatic hypotension (OH). Because midodrine hydrochloride tablets can cause marked elevation of supine blood pressure (BP>200 mmHg systolic), it should be used in patients whose lives are considerably impaired despite standard

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clinical care, including non-pharmacologic treatment (such as support stockings), fluid expansion, and lifestyle alterations. This information was obtained from: https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=4c3517f3-1c68-4ade-b5f1-c488a3a335c1

5. Oxybutynin chloride extended-release tablets are a muscarinic antagonist indicated for the treatment of overactive bladder with symptoms of urge urinary incontinence, urgency, and frequency. This information was obtained from: https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=033a9242-bbf2-49d5-8403-d07e99107130

6. Spironolactone tablets are indicated for treatment of NYHA Class III-IV heart failure and reduced ejection fraction to increase survival, manage edema, and reduce the need for hospitalization for heart failure. This information was obtained from: https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=beaf74db-4159-3b59-ef99-575c3ac99aa1

3. The facility staff failed to notify the physician when Resident #50's blood sugar reading was 50.

Resident #50 was admitted to the facility on 1/6/14 and readmitted on 4/13/18 with diagnoses that included but were not limited to type two diabetes, atrial fibrillation, heart failure, and high blood pressure. Resident #50's most recent MDS (minimum data set) assessment was an annual assessment with an ARD (assessment reference date) of 5/7/18. Resident #50 was coded as being cognitively intact in the ability to make daily decisions, scoring 12 out of 15 on the BIMS (Brief

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Interview for Mental Status) exam.

Review of Resident #50's April 2018 POS (physician order summary) revealed that she received Humalog (1) sliding scale insulin. The following order was documented:

"Humalog KwikPen Solution Pen-Injector 100 Unit/ML (milliliter) (insulin lispro) Inject per sliding scale:
If 141-180=4 units
181-220=6 units
221-260=8 units
261-300=10 units
301-350 = 12 units
351-400 =16 units 401 or greater 16 units and call MD (medical doctor), subcutaneously before meals and at bedtime for DM (diabetes mellitus)."

Review of Resident #50's April 2018 MAR (medication administration record) revealed that on 4/6/18 at 11:30 a.m., her blood sugar was 50. There was no evidence that the physician was notified of this low blood sugar. There was no evidence that the nurse had put an intervention in place to increase her blood sugar. Resident #50's Humalog was documented as held that shift.

Further review of Resident #50's meal intake report revealed that she had consumed 26-50 percent of her lunch that day.

Review of Resident #50's nursing notes revealed that on 4/6/18 at 4:37 p.m., Resident #50's blood sugar had risen to 80. At 4:45 p.m., Resident #50's blood sugar dropped down to 70 and then fifteen minutes later Resident #50 was unresponsive due to her blood sugar dropping to

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32. There was evidence that the physician was notified at this time of Resident #50's unresponsiveness despite interventions to increase the blood sugar.

Review of Resident #50's diabetes care plan dated 3/14/18, documented the following: "Blood SU (sugar): At risk for fluctuation blood sugars R/T (related/to) Diabetes. Goal: Guest will be free from signs of complications from fluctuation blood sugars such as mental status changes...observe and document s/sx (symptoms) of complications from fluctuating blood sugar. Report abnormal findings to physician."

On 6/21/18 at 1:18 p.m., an interview was conducted with LPN (licensed practical nurse) #4, the nurse who worked with Resident #50 on 4/6/18 at 11:30 a.m. When asked what she considered a low blood sugar, LPN #4 stated that it depended on the patient. When asked what she considered hypoglycemic (2), LPN #4 stated, "anything under 60." When asked the nursing process if a resident were to be hypoglycemic, LPN #4 stated that she would immediately give the resident juice to bring it up, recheck the blood sugar, monitor the resident closely, and then recheck the blood sugar again in thirty minutes. When asked if she would document these interventions, LPN #4 stated, "Yes." LPN #4 stated that she would document these interventions in a nursing note. When asked if she would notify the physician for a blood sugar reading of 50, LPN #4 stated, "I guess so. I would definitely make sure that the blood sugar had gone up." When asked about the protocol to use Glucagon (3), LPN #4 stated that she would use glucagon only if there was an order to use

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glucagon. LPN #4 stated that glucagon was not a standing order and she would have to call the physician to obtain an order. When asked if she was familiar with Resident #50, LPN #4 stated that she worked with Resident #50 on a number of occasions. When asked if she could recall Resident #50's blood sugar reading being 50 on 4/6/18 at 11:30 a.m., LPN #4 stated that she could not remember that far back. When asked if the initials on the MAR (medication administration record) were hers, LPN #4 stated, "Yes." When asked if the physician was notified regarding the low blood sugar reading of 50 at 11:30 a.m. on 4/6/18, LPN #4 stated that she was not sure and should have documented that information in a nursing note. LPN #4 could not determine either way if she had put an intervention in place. LPN #4 stated, "Maybe the 50 was a miscoding?" LPN #4 stated that if a blood sugar was that low she would stop and call the MD (medical doctor). When asked how this writer and other nurses would know what was done for Resident #50, LPN #4 stated, "You mean to tell me I recorded that her sugar was 50, and I didn't do anything?"

On 6/21/18 at 1:32 p.m., an interview was conducted with LPN #3. When asked what she considered hypoglycemic, LPN #3 stated, "Anything below 60." When asked the process followed by staff if she were to have a resident with a blood sugar level of below 60, LPN #3 stated that she would provide the resident orange juice, graham crackers with peanut butter for protein, and she would check on them every 15 minutes. LPN #3 stated that if food interventions did not work, she would notify the MD to obtain an order for glucagon and administer. LPN #3 stated she would still notify the MD for any hypoglycemic episode. LPN #3 stated, "It's something critical

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that happened to the resident." LPN #3 stated that she would always document interventions that were put into place and that the MD was made aware in a nursing note. When asked how nurses would know if interventions were put into place for a low blood sugar or that the physician was notified if there is no documentation in the clinical record, LPN #3 stated that the nurse may have put it on the 24 hour report. LPN #3 stated that if the nurse did not document on the 24-hour report than there was no was of knowing what was done.

The 24-hour report for 4/6/18 was requested from ASM (administrative staff member) #2, the DON (Director of Nursing).

On 6/21/18 at approximately 2 p.m., the 24-hour report was presented for 4/6/18. The 7-3 shift box was completely blank.

On 6/21/18 at 1:56 p.m., an interview was conducted with ASM #3, the nurse practitioner. ASM #3 could not recall being made aware of Resident #50's low blood sugar. ASM #3 stated that she probably would have given an order to monitor and maybe administer glucagon. ASM #3 stated that a blood sugar reading under 70 was considered hypoglycemic. ASM #3 stated that she would first expect nursing to give juice, recheck in an hour and hold any ordered insulin. ASM #3 that she would expect nursing to make here aware of any hypoglycemic event. ASM #3 stated that nursing staff may have notified her but they just didn't document.

On 6/22/18 at 12:02 p.m., ASM #1, the administrator, ASM #2, the DON (Director of Nursing), and ASM #4, the Regional Director of

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Operations, were made aware of the above concerns.

The facility policy titled, "Physician notification," documents in part, the following: "The licensed nurse will report changes in the guest's condition due to illness, exacerbation of existing condition, or accidents and incidents to the physician, nurse practitioner, or physician assistant, following the established interact protocols for immediate, not-immediate, or routine notification. Procedure: 1. Notify the physician of a change in the guest's condition. 2. Document the time and date that the physician was notified, the physician's response and any treatment ordered in the Progress Notes."

No further information was provided by completion of the survey.

(1) Humalog-Insulin lispro protamine and insulin lispro is a combination of a fast-acting insulin and an intermediate-acting type of human insulin. Insulin is used by people with diabetes to help keep blood sugar levels under control. This information was obtained from The National Institutes of Health. https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0010739/?report=details.

(2) Hypoglycemia means low blood glucose, or blood sugar. Your body needs glucose to have enough energy. After you eat, your blood absorbs glucose. If you eat more sugar than your body needs, your muscles, and liver store the extra. When your blood sugar begins to fall, a hormone tells your liver to release glucose. In most

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F 580	Continued From page 23 people, this raises blood sugar. If it doesn't, you have hypoglycemia, and your blood sugar can be dangerously low. Signs include Hunger, Shakiness, Dizziness, Confusion, Difficulty speaking, Feeling anxious or weak. In people with diabetes, hypoglycemia is often a side effect of diabetes medicines. Eating or drinking something with carbohydrates can help. This information was obtained from The National Institutes of Health. https://medlineplus.gov/hypoglycemia.html. Hypoglycemia, also called low blood glucose or low blood sugar, occurs when the level of glucose in your blood drops below normal. For many people with diabetes, that means a level of 70 milligrams per deciliter (mg/dL) or less. This information was obtained from The National Institutes of Health. https://www.niddk.nih.gov/health-information/diabetes/overview/preventing-problems/low-blood-glucose-hypoglycemia. (3) Glucagon injection is an emergency medicine used to treat severe hypoglycemia (low blood sugar) in diabetes patients. This information was obtained from The National Institutes of Health. https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0010481/?report=details.	F 580		
F 583 SS=D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes	F 583		8/3/18

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F 583	Continued From page 24 accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview and facility document review, it was determined that the facility staff failed to maintain a resident's privacy during incontinence care for one of 32 residents in the survey sample, Resident # 32. The facility staff failed to maintain privacy for Resident # 32 covered during incontinence care.	F 583	Resident #32 is receiving incontinence care daily and privacy is being provided. A quality review of current residents receiving incontinence care has been performed. Licensed Nursing Staff re-educated by DON or Designee regarding ensuring that privacy curtains are used when providing	

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F 583	Continued From page 25 The findings included: Resident # 32 was admitted to the facility on 08/12/16 with diagnoses that included but were not limited to Alzheimer's disease (1), anxiety (2), and dysphagia (3). On 06/19/18 at approximately 6:30 p.m., during the initial tour of the facility an observation of Resident # 32's and Resident # 32's room was conducted. During the tour, Resident # 32's room door was closed. When this surveyor knocked on the door, staff inside the room stated to come in. Upon entering the room and standing just inside the room, Resident # 32 was observed on the B-side of the room, next to the window, the privacy curtain between the A-side and B-side beds was pulled approximately one-third away from the wall exposing Resident # 32 from her waist to her feet. Further observation revealed Resident # 32 was uncovered from her waist to her feet exposing the brief Resident # 32 was wearing. Resident # 32's roommate and visitor were present in the room at the time of the observation on the A-side of the room. They were observed crowded behind the partially closed privacy curtain. Resident # 32's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 04/19/18, coded Resident # 32 as scoring a 0 (zero) on the brief interview for mental status (BIMS) of a score of 0 - 15, 0 (zero) - being severely impaired of cognition for making daily decisions. Resident # 32 was coded as requiring extensive assistance of one staff member for activities of daily living. On 06/22/18 at 8:20 a.m., an interview was	F 583	care to residents. DON/Designee will conduct quality monitoring for the use of privacy curtains during resident care five times a week x1, weekly x4 and then monthly, PRN and as indicated. Findings to be communicated to the QA committee monthly and as indicated. Quality monitoring schedules will be modified as indicated based on findings.	

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conducted with CNA (certified nursing assistant) # 1. When asked to describe the procedure for maintaining a resident's dignity while providing incontinence care to a resident CNA # 1 stated, "During care I keep the area of the resident's body I'm working on covered with a sheet or the gown if they are wearing one." When asked how the reasonable person would feel if they were exposed like, Resident # 32 was observed when receiving personal/incontinence care, CNA # 1 stated, "They wouldn't feel comfortable because no one would want to be exposed to someone who is not taking care of them and their sense of modesty would be violated."

Attempts were made during the days of the survey to interview Resident # 32's roommate and visitor who was present during the observation of Resident # 32 on 06/19/18. The attempts were unsuccessful due to the unavailability of Resident # 32's roommate and visitor.

The facility's "Resident Rights & Facility Responsibilities" documented, "(h) Privacy and confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. (1) Scope of Personal Privacy. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident."

On 06/22/18 at approximately 12:00 p.m., ASM (administrative staff member) # 1, administrator, ASM # 2, director of nursing were made aware of the above findings.

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F 583	Continued From page 27 No further information was provided prior to exit. References: (1) A brain disorder that seriously affects a person's ability to carry out daily activities) This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/alzheimersdisease.html. (2) Fear. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/anxiety.html#summary. (3) A swallowing disorder. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/swallowingdisorders.html.	F 583		
F 622 SS=E	Transfer and Discharge Requirements CFR(s): 483.15(c)(1)(i)(ii)(2)(i)-(iii) §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- (i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; (C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; (D) The health of individuals in the facility would	F 622		8/3/18

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otherwise be endangered;
(E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or
(F) The facility ceases to operate.
(ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose.

§483.15(c)(2) Documentation.
When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider.
(i) Documentation in the resident's medical record must include:
(A) The basis for the transfer per paragraph (c)(1)(i) of this section.

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F 622	Continued From page 29 (B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s). (ii) The documentation required by paragraph (c)(2)(i) of this section must be made by- (A) The resident's physician when transfer or discharge is necessary under paragraph (c) (1) (A) or (B) of this section; and (B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, and clinical record review, it was determined that facility staff failed to evidence that all the required information was provided to the receiving provider for a facility-initiated transfer for five of 32 residents in the survey sample, Resident #46, #50, #39, #110, and #64. 1. For Resident #46, facility staff failed to	F 622	Resident #46 returned to the facility. No negative outcome has occurred from this practice. Resident #50 returned to the facility. No negative outcome has occurred from this practice. Resident #39 returned to the facility. No negative outcome has occurred from this practice. Resident #110 did not return to the facility. No negative outcome has occurred from	

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F 622	Continued From page 30 evidence that all the required information was provided to the receiving provider for a facility-initiated transfer on 6/8/18. 2. For Resident #50, facility staff failed to evidence that all required information was provided to the receiving provider for a facility-initiated transfer on 3/9/18 and 4/6/18. 3. For Resident #39, the facility staff failed to evidence that all required information was provided to the hospital upon a transfer to the hospital on 4/19/18. 4. For Resident #110, the facility staff failed to evidence that all required information was provided to the hospital upon a transfer to the hospital on 3/21/18. 5. For Resident # 64, the facility staff failed to evidence that all required documentation and information was provided to the receiving provider for a facility-initiated transfer on 06/12/18. The findings include: 1. Resident #46 was admitted to the facility on 6/9/14 and readmitted on 6/13/18 with diagnoses that included but were not limited to muscle weakness, urine retention, post stroke, acquired absence of other specified parts of digestive tract with a gastronomy (1) and jejunostomy tube (2), high blood pressure, and diabetes. Resident #46's most recent MDS (minimum data set) assessment was a 60 day scheduled assessment with an ARD (assessment reference date) of 5/9/18. Resident #46 was coded as being cognitively intact in the ability to make daily decisions scoring 12 out of possible 15 on the	F 622	this practice. Resident #64 returned to the facility. No negative outcome has occurred from this practice. All residents have the potential to be affected. Licensed Nurses to be educated by DON/Designee regarding providing information to the receiving provider for a facility-initiated transfer. DON/Designee will conduct quality monitoring of facility initiated transfers, 5x a week x1 week, weekly x4 weeks and then monthly, PRN and as indicated. Findings to be communicated to the QA committee monthly and as indicated. Quality monitoring schedules will be modified as indicated based on findings.	

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BIMS (Brief Interview for Mental Status) exam.

Review of Resident #46's clinical record revealed that he had gone out to the hospital on 6/8/18.

A SBAR (Situation, Background, Assessment and Recommendation) form dated 6/8/18, documented in part, the following: "Mental Status Evaluation: Decreased level of consciousness...Respiratory Evaluation: Cough, Productive...Abdominal Evaluation: Abdominal pain/tenderness/distended abdomen...Summarize your observations and evaluation: Please evaluate for possible abscess near the JTUBE (jejunostomy tube) site, fever, pain and copious foul smelling drainage. Primary Care Clinician Notified: (Name of NP (nurse practitioner) Date: 6/8/18 at 11:30 a.m., Recommendations of Primary Clinicians (if any): Send to ER (emergency room) for Evaluation."

Review of the Nursing Home to Hospital Transfer Form dated 6/8/18 evidenced Resident #46's contact information of the practitioner responsible for the care of the resident, resident representative information including contact information, advance directive information and all special instructions or precautions for ongoing care, as appropriate.

There was no evidence that Resident #46's comprehensive care plan or comprehensive care plan goals were sent with the resident at the time of transfer.

On 6/22/18 at 9:20 a.m., an interview was conducted with LPN (licensed practical nurse) #1. When asked what information was on the transfer form, LPN #1 stated everything from the

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assessment to the resident's contact information (RP/MD [responsible party/ medical doctor]). When asked if the CCP (comprehensive care plan) or comprehensive care plan goals were sent with the resident at the time of transfer, LPN #1 stated that the comprehensive care plan or care plan goals were not sent with the resident.

On 6/22/18 at 12:02 p.m., ASM #1, the administrator, ASM #2, the DON (Director of Nursing), and ASM #4, the Regional Director of Operations, were made aware of the above concerns.

The facility policy titled, "Transferring Guest to the Hospital," documents in part, the following: "Following a physician's order, nursing personnel will complete the appropriate forms for transfer to an acute care setting, thus ensuring continuity of care. This transfer may be unanticipated due to a change in a guests condition, or anticipated related to a planned procedure, testing etc...Complete the facility transfer form, copy the most recent monthly physician's order sheet, the guest's Medication Administration Record (MAR), and the guest's advanced directive."

(1) Gastronomy- A percutaneous endoscopic gastronomy tube can be used to deliver nutrition, hydration and medicines directly into the patient's stomach. Patients will require a tube if they are unable to swallow safely, putting them at risk of aspiration of food, drink and medicines into their lungs. This information was obtained from The National Institutes of Health. https://www.ncbi.nlm.nih.gov/pubmed/26016095.

(2) Jejunostomy allows a feeding tube to be put into the small intestine. This information was

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obtained from The National Institutes of Health. https://www.cancer.gov/publications/dictionaries/cancer-terms/def/jejunostomy.

2. For Resident #50, facility staff failed to evidence that all required information was provided to the receiving provider for a facility-initiated transfer on 3/9/18 and 4/6/18.

Resident #50 was admitted to the facility on 1/6/14 and readmitted on 4/13/18 with diagnoses that included but were not limited to type two diabetes, atrial fibrillation, heart failure, and high blood pressure. Resident #50's most recent MDS (minimum data set) assessment was an annual assessment with an ARD (assessment reference date) of 5/7/18. Resident #50 was coded as being cognitively intact in the ability to make daily decisions, scoring 12 out of 15 on the BIMS (Brief Interview for Mental Status) Exam.

Review of Resident #50's clinical record revealed that she was transferred to the hospital on 3/9/18 due to a fall. The following was documented: "Found on floor next to bed on R (right) side at 4:05 p.m. No neuro changes noted. Pulse is 124 RR (respirations) is 24 BP (blood pressure) is 134/92. Unable to extend R leg in bed, c/o (complained) pain in hip area. Physician notified and order received to send guest out at 4:10 p.m. Daughter (Name of daughter), notified, and requests (Name of hospital). Transported at this time to (Name of hospital) via (Name of EMT [emergency medical transport] Service). "

The next note dated 3/9/18 documented the following: "Interfacility transfer sheet, copy of current orders, copy of code sheet and face sheet

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sent with squad for ER (emergency room) at (Name of hospital)."

There was no evidence that Resident #50's comprehensive care plan goals were sent with the resident at the time of transfer on 3/9/18.

Review of Resident #50's nursing notes revealed that she arrived back to the facility on 3/13/18 with diagnoses of a hip fracture and post surgical repair.

Further review of Resident #50's clinical record revealed she was transferred to the hospital for the second time on 4/6/18. The following was documented: "Blood Sugar at 4:45 pm 70 and taken in R (right) hand. Guest is drowsy. CNA (certified nursing assistant) enters room for VS (vital signs) at 5 pm and guest is unresponsive with VS and FSBS (fasting blood sugar) of 22 at 5:05 p.m. Cool H20 (water) and washcloths used to attempt to get verbal response without success. At 5:10 p.m., blood sugar at 32 with Glucagon (1) given and 911 called from nurses station per staff. Pulse is 102, RR (respiratory rate) 16, BP (blood pressure) 134/82 manually. Attempt made to call daughter from guests portable phone in room at this time unsuccessful, no answer, EMTs (emergency medical technicians) arrived at 5:15 p.m. with report given verbally with vital signs and blood glucose results written. DON (Director of Nursing) texted at this time with information and message left on on-call physician's emergency number for (Name or physician) at this time."

There was no evidence that the following information was sent with Resident #50 at the time of transfer on 4/6/18:

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1) Contact information of the practitioner responsible for the care of the resident.
2) Resident representative information including contact information
3) Advance Directive information
4) All special instructions or precautions for ongoing care, as appropriate.
5) Comprehensive care plan goals

Further review of Resident #50's clinical record revealed that Resident #50 returned to the facility on 4/13/18.

The hospital physician documented the following: "Hypoglycemia (2): etiology is unclear. I was initially concerned about a medication error but her hypoglycemia was so profound (down in the 20s on admission and still dipping into the 20s on a D 10 (10 % Dextrose (sugar) drip and persisted for 3 days in the face of dextrose (sugar) boluses, dextrose IV (intravenous) continuous, infusions and eating." Further review of Resident #50's hospital records revealed that she also had a diagnosis of a UTI (urinary tract infection).

On 6/22/18 at 9:20 a.m., an interview was conducted with LPN (licensed practical nurse) #1. When asked what information was on the transfer form, LPN #1 stated everything from the assessment to the resident's contact information (RP/MD [responsible party/ medical doctor]). When asked if the CCP (comprehensive care plan) or comprehensive care plan goals were sent with the resident at the time of transfer, LPN #1 stated that the comprehensive care plan or care plan goals were not sent with the resident.

On 6/22/18 at 12:02 p.m., ASM #1, the

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administrator, ASM #2, the DON (Director of Nursing), and ASM #4, the Regional Director of Operations, were made aware of the above concerns. A transfer sheet for Resident #50's second hospitalization on 4/6/18 could not be provided.

(1) Glucagon injection is an emergency medicine used to treat severe hypoglycemia (low blood sugar) in diabetes patients. This information was obtained from The National Institutes of Health. https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0010481/?report=details.

(2) Hypoglycemia means low blood glucose, or blood sugar. Your body needs glucose to have enough energy. After you eat, your blood absorbs glucose. If you eat more sugar than your body needs, your muscles, and liver store the extra. When your blood sugar begins to fall, a hormone tells your liver to release glucose. In most people, this raises blood sugar. If it doesn't, you have hypoglycemia, and your blood sugar can be dangerously low. Signs include Hunger, Shakiness, Dizziness, Confusion, Difficulty speaking, Feeling anxious or weak. In people with diabetes, hypoglycemia is often a side effect of diabetes medicines. Eating or drinking something with carbohydrates can help. This information was obtained from The National Institutes of Health. https://medlineplus.gov/hypoglycemia.html.

Hypoglycemia, also called low blood glucose or low blood sugar, occurs when the level of glucose in your blood drops below normal. For many people with diabetes, that means a level of 70 milligrams per deciliter (mg/dL) or less. This

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information was obtained from The National Institutes of Health. https://www.niddk.nih.gov/health-information/diabetes/overview/preventing-problems/low-blood-glucose-hypoglycemia.

3. For Resident #39, the facility staff failed to evidence that all required information was provided to the hospital upon a transfer to the hospital on 4/19/18.

Resident #39 was admitted to the facility on 6/13/17 and readmitted on 4/26/18 after a brief hospitalization, with the diagnoses of but not limited to stroke, hemiplegia, Parkinson's disease, diabetes, anxiety disorder, benign prostatic hyperplasia, dementia, dysphagia, spinal stenosis, high blood pressure, osteoarthritis, alcohol abuse, and atrial fibrillation. The most recent MDS (Minimum Data Set) was a significant change assessment with an ARD (Assessment Reference Date) of 5/4/18. The resident was coded as severely cognitively impaired in ability to make daily life decisions.

A review of the clinical record revealed that the resident went to the hospital on 4/19/18. A review of the nurse's notes failed to reveal any date for when the resident went to the hospital.

On 6/21/18 at 4:35 p.m., in an interview with RN #1 (Registered Nurse), she stated that when a resident is sent to the hospital, nursing is supposed to write a note why someone went to the hospital, and complete the "Interact" form.

A review of the clinical record revealed the "Nursing Home to Hospital Transfer Form" and "Interact" form, which documented the following

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information:
Resident demographic information, where being sent to and sent from. RP name and number, MD (medical doctor) name and number, Code Status, Clinical Information, Usual Mental Status, Usual Functional Status, Additional Clinical Information, Devices and Treatments, Isolation Precautions, Allergies, Risk Alerts, Personal Belongings Sent, Nursing Home ability to accept patient back, Report called by and to, Nursing Home contact information, Social Worker, Family and Other Social Issues, Behavioral Issues, Primary Goals at Time of Transfer (specifically documented as 1. Rehabilitation and/or Medical Therapy with intent to returning home, 2. Chronic long-term care, 3. Palliative or end-of-life care, 4. Receiving hospice care, 5. Other), Treatments and Frequency, Diet, Skin/Wound Care, Immunizations, Physical Therapy, ADLs status, Impairments-General, Impairments-Musculoskeletal, Incontinence, Additional Relevant Information, Form Completed By section.

The section for Goals did not include care plan goals. There was no other area specifically designated as care plan goals.

On 6/22/18 at 10:02 a.m., in an interview with RN #1, regarding the information sent with residents transferred to the hospital. RN #1 stated, "The transfer form." When asked, what information is included on the transfer form, RN #1 stated, "The assessment." When asked, if a copy of the comprehensive care plan or care plan goals is sent with residents, RN #1 shook her head "no."

On 6/22/18 at 12:30 p.m., ASM #1 (Administrative Staff Member, the Administrator) and ASM #2

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(the Director of Nursing) were made aware of the findings. No further information was provided by the end of the survey.

4. For Resident #110, the facility staff failed to evidence that all required information was provided to the hospital upon a transfer to the hospital on 3/21/18

Resident #110 was admitted to the facility on 3/14/18 and discharged on 3/21/18 with the diagnoses of but not limited to respiratory failure, chronic thrombosis, alcohol abuse, cervicalgia, pressure ulcer, dysphagia, schizoaffective disorder, benign prostatic hyperplasia, and chronic obstructive pulmonary disease. The most recent MDS (Minimum Data Set) was an admission/5-day assessment with an ARD (Assessment Reference Date) of 3/21/18. The MDS was incomplete due to the resident leaving prior to the completion of the MDS.

A review of the clinical record revealed that the resident went to the hospital on 3/21/18. The resident did not return. A nurse's note dated 3/21/18 at 4:00 a.m., documented, "Noted on the first round at 1230 a.m., guest HOB (head of bed) elevated and had abnormal breathing, breathing thru his mouth. noted yellow drainage coming from out his mouth on to a towel on his chest. Guest did not respond to no {sic} stimli {sic}. Eyes were rolled to the back of his head. Fingernails were cold and blue. Lung sounds to upper bases were full. VS (vital signs) 98.9 (temperature), 110 (pulse), 24 (respirations), 168/88 (blood pressure), unable to obtain a pox (pulse oximetry reading [reading of oxygen saturations]). MD/DON/RP (medical

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doctor/director of nursing/responsible party) notified w/N.O. (with new order) send guest to (name of hospital) to eval (evaluate) and tx (treat), noted and received. Called 911 dispatch at at {sic} 1240a.m.. Several EMT'S (Emergency Medical Technician) arrived at 1245 a.m., and carried guest out via stretcher."

Further review of the clinical record failed to reveal any documentation of any information sent to or provided to the hospital for the above facility-initiated transfer.

On 6/21/18 at 4:35 p.m., in an interview with RN #1 (Registered Nurse), she stated that when a resident is sent to the hospital, nursing is supposed to write a note why someone went to the hospital, and complete the "Interact" form.

A review of a copy of the "Nursing Home to Hospital Transfer Form" and the "Interact" form used by the facility revealed there was no evidence that either the form, or any similar form, or the required data, was completed and sent to the hospital with the resident.

On 6/22/18 at 10:02 a.m., in an interview with RN #1, regarding the information sent with residents transferred to the hospital. RN #1 stated, "The transfer form." When asked, what information is included on the transfer form, RN #1 stated, "The assessment." When asked, if a copy of the comprehensive care plan or care plan goals is sent with residents, RN #1 shook her head "no."

On 6/22/18 at 12:30 p.m., ASM #1 (Administrative Staff Member, the Administrator) and ASM #2 (the Director of Nursing) were made aware of the

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findings. The facility was not able to locate any evidence that any transfer paperwork and documentation was completed and sent with the resident on 3/21/18.

No further information was provided by the end of the survey.

5. For Resident # 64, the facility staff failed to evidence that all required documentation and information was provided to the receiving provider for a facility-initiated transfer on 06/12/18.

Resident # 64 was admitted to the facility on 02/14/18 with a readmission of 03/13/18 with diagnoses that included but were not limited to malignant neoplasm (1) of the larynx (2), gastroesophageal reflux disease (3), chronic obstructive pulmonary disease (4), tracheostomy (5) and benign prostatic hyperplasia (6).

Resident # 64's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 05/18/18, coded Resident # 64 as scoring a 14 on the brief interview for mental status (BIMS) of a score of 0 - 15, 14 - being cognitively intact for making daily decisions.

The nurse's "Progress Notes" for Resident # 64 dated 06/12/18 documented, "22:30 (10:22 p.m.) Following up from previous shift. Guest lab (laboratory) results critical. N.O. (new order) from MD (medical doctor, Name of Physician) to send guest to (Name of Hospital) for further evaluation. RP (responsible party) notified. (Name of RP) wanted to transport guest. Guest sent out via (by) w/c (wheelchair) accompanied by RP to (Name of Hospital)."

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The nurse's "Progress Notes" for Resident # 64 dated 06/13/18 documented in part, "19:313 (7:13 p.m.) Guest arrived via w/c from (Name of Hospital) accompanied by RP (Name of RP). Guest made comfortable in room by writer and CNA (certified nursing assistant), RP at bedside ..."

On 06/22/18 at 10:00 a.m., an interview was conducted with RN (registered nurse) # 1. When asked describe what documentation is provided to the receiving facility when a resident is transferred RN # 1 stated, "The RP and physician are notified by phone, a bed hold policy is offered by nursing at the time of the transfer, and a transfer form is completed and sent with the resident." When asked if a copy of the resident's comprehensive care plan or their care plan goals are sent with the resident at the time of the transfer, RN # 1 stated, "No."

Review of the facility's transfer form entitled "Inter-Facility Continuity of Care Report" for Resident # 64 failed to evidence the resident's comprehensive care plan goals as part of the transfer paperwork.

Review of Resident # 64's clinical record failed to evidence the receiving facility received a copy of Resident # 64's comprehensive care plan goals.

On 06/22/18 at approximately 12:00 p.m., ASM (administrative staff member) # 1, administrator, ASM # 2, director of nursing were made aware of the above findings.

No further information was provided prior to exit.

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References:
(1) The term "malignancy" refers to the presence of cancerous cells that have the ability to spread to other sites in the body (metastasize) or to invade nearby (locally) and destroy tissues. Malignant cells tend to have fast; uncontrolled growth and DO NOT die normally due to changes in their genetic makeup. Malignant cells that are resistant to treatment may return after all detectable traces of them have been removed or destroyed. This information was obtained from the website: https://medlineplus.gov/ency/article/002253.htm.

(2) The larynx, or voice box, is located in the neck and performs several important functions in the body. The larynx is involved in swallowing, breathing, and voice production. Sound is produced when the air which passes through the vocal cords causes them to vibrate and create sound waves in the pharynx, nose and mouth. The pitch of sound is determined by the amount of tension on the vocal folds. This information was obtained from the website: https://medlineplus.gov/ency/imagepages/19708.htm.

(3) Stomach contents to leak back, or reflux, into the esophagus and irritate it. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/gerd.html.

(4) Disease that makes it difficult to breath that can lead to shortness of breath). This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/copd.html.

(5) A surgical procedure to create an opening through the neck into the trachea (windpipe). A

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F 622	Continued From page 44 tube is most often placed through this opening to provide an airway and to remove secretions from the lungs. This tube is called a tracheostomy tube or trach tube. This information was obtained from the website: https://medlineplus.gov/ency/article/002955.htm. (6) An enlarged prostate. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/enlargedprostatebph.html.	F 622		
F 623 SS=E	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable	F 623		8/3/18

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before transfer or discharge when-
(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;
(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;
(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;
(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with

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F 623	Continued From page 46 developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, and clinical record review, it was determined that facility staff failed to provide written notification to the resident representative of a facility initiated transfer to the hospital for five of 32 residents in the survey sample, Resident #46, #50, #39, #110, and #64.	F 623	The responsible party for resident #46 is aware of resident's transfer to the hospital. The responsible party for resident #50 is ware of resident's transfer to the hospital. The Ombudsman has been made aware of #39s discharge to the hospital. The responsible party for resident #110 is	

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F 623	Continued From page 47 1. For Resident #46, facility staff failed to provide written notification to the responsible party for a transfer to the hospital on 6/8/18. 2. For Resident #50, facility staff failed to provide written notification to the responsible party for a transfer to the hospital on 3/9/18 and 4/6/18. 3. For Resident #39, the facility staff failed to evidence that the responsible party and ombudsman was provided with written notification of the hospital transfer of 4/19/18. 4. For Resident #110, the facility staff failed to evidence that the responsible party was provided with written notification of the hospital transfer of 3/21/18. 5. For Resident # 64, the facility staff failed to provide written notification to the resident and responsible party (RP) and of a facility initiated transfer to the hospital on 06/12/18. The findings include: 1. Resident #46 was admitted to the facility on 6/9/14 and readmitted on 6/13/18 with diagnoses that included but were not limited to muscle weakness, urine retention, post stroke, acquired absence of other specified parts of digestive tract with a gastronomy (1) and jejunostomy tube (2), high blood pressure, and diabetes. Resident #46's most recent MDS (minimum data set) assessment was a 60 day scheduled assessment with an ARD (assessment reference date) of 5/9/18. Resident #46 was coded as being cognitively intact in the ability to make daily decisions scoring 12 out of possible 15 on the	F 623	aware of resident's transfer to the hospital. The responsible party for resident #64 is aware of resident's transfer to the hospital. All residents have the potential to be affected. Licensed Nursing Staff to be educated by DON/designee regarding providing written notification to the responsible party when residents are transferred out of the facility. The Administrator will be in-serviced to assure all quests who discharge from the facility are listed on the report sent to the Ombudsman. DON/Designee during morning clinical meeting to conduct quality monitoring of transfers out of the facility to ensure written notification is provided to the responsible party 5x week x1 week, then weekly x4 weeks, monthly and then PRN. The Administrator will review the list of discharges sent to the Ombudsman to assure all residents are listed. Findings to be communicated to the QA committee monthly and as indicated. Quality monitoring schedules modified based on findings.	

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BIMS (Brief Interview for Mental Status) exam.

Review of Resident #46's clinical record revealed that he had gone out to the hospital on 6/8/18.

A SBAR (Situation, Background, Assessment and Recommendation) form dated 6/8/18, documented in part, the following: "Mental Status Evaluation: Decreased level of consciousness...Respiratory Evaluation: Cough, Productive...Abdominal Evaluation: Abdominal pain/tenderness/distended abdomen...Summarize your observations and evaluation: Please evaluate for possible abscess near the JTUBE (jejunostomy tube) site, fever, pain and copious foul smelling drainage. Primary Care Clinician Notified: (Name of NP (nurse practitioner) Date: 6/8/18 at 11:30 a.m., Recommendations of Primary Clinicians (if any): Send to ER (emergency room) for Evaluation."

Review of Nursing Home to Hospital Transfer form revealed that Resident #46's responsible party was notified of the transfer via phone. There was no evidence that written notification was provided to the resident or responsible party documenting the reason for transfer on 6/8/18.

On 6/22/18 at 9:20 a.m., an interview was conducted with LPN (licensed practical nurse) #1. When asked if she would provide written notification to the resident or representative explaining the reason for hospital transfer, LPN #1 stated the nursing provides verbal notification and not written.

On 6/22/18 at 9:35 a.m., an interview was conducted with OSM (other staff member) 1, the social worker. OSM #1 stated that she was not

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THE LAURELS OF BON AIR	9101 BON AIR CROSSINGS DRIVE BON AIR, VA 23235

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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involved with hospital transfers.

On 6/22/18 at 12:02 p.m., ASM #1, the administrator, ASM #2, the DON (Director of Nursing), and ASM #4, the Regional Director of Operations, were made aware of the above concerns.

The facility policy titled, "Transferring Guest to the Hospital," did not address the above concerns.

(1) Gastronomy- A percutaneous endoscopic gastronomy tube can be used to deliver nutrition, hydration and medicines directly into the patient's stomach. Patients will require a tube if they are unable to swallow safely, putting them at risk of aspiration of food, drink and medicines into their lungs. This information was obtained from The National Institutes of Health. https://www.ncbi.nlm.nih.gov/pubmed/26016095.

(2) Jejunostomy allows a feeding tube to be put into the small intestine. This information was obtained from The National Institutes of Health. https://www.cancer.gov/publications/dictionaries/cancer-terms/def/jejunostomy.

2. For Resident #50, facility staff failed to provide written notification to the responsible party for a transfer to the hospital on 3/9/18 and 4/6/18.

Resident #50 was admitted to the facility on 1/6/14 and readmitted on 4/13/18 with diagnoses that included but were not limited to type two diabetes, atrial fibrillation, heart failure, and high blood pressure. Resident #50's most recent MDS (minimum data set) assessment was an annual

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assessment with an ARD (assessment reference date) of 5/7/18. Resident #50 was coded as cognitively intact in the ability to make daily decisions, scoring 12 out of 15 on the BIMS (Brief Interview for Mental Status) Exam.

Review of Resident #50's clinical record revealed that she was transferred to the hospital on 3/9/18 due to a fall. The following was documented: "Found on floor next to bed on R (right) side at 4:05 p.m. No neuro changes noted. Pulse is 124 RR (respirations) is 24 BP (blood pressure) is 134/92. Unable to extend R (right) leg in bed, c/o (complained) pain in hip area. Physician notified and order received to send guest out at 4:10 p.m. Daughter (Name of daughter), notified, and requests (Name of hospital). Transported at this time to (Name of hospital) via (Name of EMT [emergency medical transport] Service). "

The next note dated 3/9/18 documented the following: "Interfacility transfer sheet, copy of current orders, copy of code sheet and face sheet sent with squad for ER (emergency room) at (Name of hospital)."

Review of Resident #50's clinical record failed to evidence that the RP (responsible party) was notified in writing of the reason for Resident #50's transfer to the hospital.

Further review of Resident #50's clinical record revealed that she had been transferred to the hospital for the second time on 4/6/18. The following was documented: "Blood Sugar at 4:45 pm 70 and taken in R (right) hand. Guest is drowsy. CNA (certified nursing assistant) enters room for VS (vital signs) at 5 pm and guest is unresponsive with VS and FSBS (fasting blood

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sugar) of 22 at 5:05 p.m. Cool H20 (water) and washcloths used to attempt to get verbal response without success. At 5:10 p.m., blood sugar at 32 with Glucagon (1) given and 911 called from nurses station per staff. Pulse is 102, RR (respiratory rate) 16, BP (blood pressure) 134/82 manually. Attempt made to call daughter from guests portable phone in room at this time unsuccessful, no answer, EMTs (emergency medical technicians) arrived at 5:15 p.m. with report given verbally with vital signs and blood glucose results written. DON (Director of Nursing) texted at this time with information and message left on on-call physician's emergency number for (Name or physician) at this time."

Review of Resident #50's clinical record failed to evidence that the RP (responsible party) was notified in writing of the reason for Resident #50's transfer to the hospital on 4/6/18.

On 6/22/18 at 9:20 a.m., an interview was conducted with LPN (licensed practical nurse) #1. When asked if she would provide written notification to the resident or representative explaining the reason for hospital transfer, LPN #1 stated the nursing provides verbal notification and not written.

On 6/22/18 at 9:35 a.m., an interview was conducted with OSM (other staff member) 1, the social worker. OSM #1 stated that she was not involved with hospital transfers.

On 6/22/18 at 12:02 p.m., ASM #1, the administrator, ASM #2, the DON (Director of Nursing), and ASM #4, the Regional Director of Operations, were made aware of the above concerns. No further information was presented

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prior to exit.

(1) Glucagon injection is an emergency medicine used to treat severe hypoglycemia (low blood sugar) in diabetes patients. This information was obtained from The National Institutes of Health. https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0010481/?report=details.

3. For Resident #39, the facility staff failed to evidence that the responsible party and ombudsman was provided with written notification of the hospital transfer of 4/19/18.

Resident #39 was admitted to the facility on 6/13/17 and readmitted on 4/26/18 after a brief hospitalization, with the diagnoses of but not limited to stroke, hemiplegia, Parkinson's disease, diabetes, anxiety disorder, benign prostatic hyperplasia, dementia, dysphagia, spinal stenosis, high blood pressure, osteoarthritis, alcohol abuse, and atrial fibrillation. The most recent MDS (Minimum Data Set) was a significant change assessment with an ARD (Assessment Reference Date) of 5/4/18. The resident was coded as severely cognitively impaired in ability to make daily life decisions.

A review of the clinical record revealed that the resident went to the hospital on 4/19/18. A review of the nurse's notes failed to reveal any notes dated for when the resident went to the hospital.

On 6/21/18 at 4:35 p.m., in an interview with RN #1 (Registered Nurse), she stated that when a resident is sent to the hospital, nursing is supposed to write a note why someone went to the hospital, and complete the "Interact" form.

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When asked about notifying the responsible party (RP), RN #1 stated that it is on the form, and is done by phone.
When asked about providing written notification to RP explaining reason for transfer, RN #1 shook her head "no" and stated, "No, I don't think so." When asked if nursing provides written notification of the transfer to the Ombudsman, RN #1 stated, "Nursing does not notify Ombudsman."

On 6/22/18 at 9:51 a.m., in an interview with OSM #1 (Other Staff Member, the social worker), she stated that she is not involved in any capacity when a resident is transferred to the hospital.

A review of the clinical record revealed the "Nursing Home to Hospital Transfer Form" and "Interact" form failed to evidence that the responsible party was provided with written notification. There was no evidence that the Ombudsman was provided with written notification.

A review of the facility policy, "Transferring the Guest to the Hospital" failed to include any direction for providing the responsible party and the Ombudsman with written notification of the resident's discharge.

On 6/22/18 at 12:30 p.m., ASM #1 (Administrative Staff Member, the Administrator) and ASM #2 (the Director of Nursing) were made aware of the findings.

On 6/22/18 at 12:55 p.m., ASM #1 provided a list of discharged residents that was provided to the Ombudsman. Resident # 39 was not on the list of discharges sent to the ombudsman. ASM #1 stated that Resident #39 was private pay at that

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time, and a glitch in the system was not including private pay residents on the printed discharge list the facility pulls up in the system to send to the Ombudsman. When asked if the Ombudsman was notified of Resident #39's discharge, ASM #1 stated no.

No further information was provided by the end of the survey.

4. For Resident #110, the facility staff failed to evidence that the responsible party was provided with written notification of the hospital transfer of 3/21/18.

Resident #110 was admitted to the facility on 3/14/18 and discharged on 3/21/18 with the diagnoses of but not limited to respiratory failure, chronic thrombosis, alcohol abuse, cervicalgia, pressure ulcer, dysphagia, schizoaffective disorder, benign prostatic hyperplasia, and chronic obstructive pulmonary disease. The most recent MDS (Minimum Data Set) was an admission/5-day assessment with an ARD (Assessment Reference Date) of 3/21/18. The MDS was incomplete due to the resident leaving prior to the completion of the MDS.

A review of the clinical record revealed that the resident went to the hospital on 3/21/18. The resident did not return. A nurse's note dated 3/21/18 at 4:00 a.m., documented, "Noted on the first round at 1230 a.m., guest HOB (head of bed) elevated and had abnormal breathing, breathing thru his mouth. noted yellow drainage coming from out his mouth on to a towel on his chest. Guest did not respond to no {sic} stimli {sic}. Eyes were rolled to the back of his head.

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Fingernails were cold and blue. Lung sounds to upper bases were full. VS (vital signs) 98.9 (temperature), 110 (pulse), 24 (respirations), 168/88 (blood pressure), unable to obtain a pox (pulse oximetry reading [reading of oxygen saturations]). MD/DON/RP (medical doctor/director of nursing/responsible party) notified w/N.O. (with new order) send guest to (name of hospital) to eval (evaluate) and tx (treat), noted and received. Called 911 dispatch at at {sic} 1240a.m.. Several EMT'S (Emergency Medical Technician) arrived at 1245 a.m., and carried guest out via stretcher."

Further review of the clinical record failed to reveal any evidence that the responsible party was notified in writing of the transfer to the hospital on 3/21/18.

On 6/21/18 at 4:35 p.m., in an interview with RN #1 (Registered Nurse), she stated that when a resident is sent to the hospital, nursing is supposed to write a note why someone went to the hospital, and complete the "Interact" form. When asked about notifying the responsible party (RP), RN #1 stated that it is on the form, and is done by phone. When asked about providing written notification to RP explaining reason for transfer, RN #1 shook her head "no" and stated, "No, I don't think so." When asked if nursing provides written notification of the transfer to the Ombudsman, RN #1 stated, "Nursing does not notify Ombudsman."

On 6/22/18 at 9:51 a.m., in an interview with OSM #1 (Other Staff Member, the social worker), she stated that she is not involved in any capacity when a resident is transferred to the hospital.

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A review of the clinical record revealed the "Nursing Home to Hospital Transfer Form" and "Interact" form failed to evidence that the responsible party was provided with written notification. There was no evidence that the Ombudsman was provided with written notification.

On 6/22/18 at 12:30 p.m., ASM #1 (Administrative Staff Member, the Administrator) and ASM #2 (the Director of Nursing) were made aware of the findings. The facility was not able to locate any evidence that any transfer paperwork and documentation was completed for Resident #110's facility initiated 3/21/18 transfer to the hospital.

No further information was provided by the end of the survey.
5. The facility staff failed to provide written notification to the resident and responsible party (RP) and of a facility initiated transfer to the hospital on 06/12/18 for Resident # 64.

Resident # 64 was admitted to the facility on 02/14/18 with a readmission of 03/13/18 with diagnoses that included but were not limited to malignant neoplasm (1) of the larynx (2), gastroesophageal reflux disease (3), chronic obstructive pulmonary disease (4), tracheostomy (5) and benign prostatic hyperplasia (6).

Resident # 64's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 05/18/18, coded Resident # 64 as scoring a 14 on the brief interview for mental status (BIMS) of a score of 0

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F 623	Continued From page 57 - 15, 14 - being cognitively intact for making daily decisions. The nurse's "Progress Notes" for Resident # 64 dated 06/12/18 documented, "22:30 (10:22 p.m.) Following up from previous shift. Guest lab (laboratory) results critical. N.O. (new order) from MD (medical doctor, Name of Physician) to send guest to (Name of Hospital) for further evaluation. RP (responsible party) notified. (Name of RP) wanted to transport guest. Guest sent out via (by) w/c (wheelchair) accompanied by RP to (Name of Hospital)." The nurse's "Progress Notes" for Resident # 64 dated 06/13/18 documented in part, "19:313 (7:13 p.m.) Guest arrived via w/c from (Name of Hospital) accompanied by RP (Name of RP). Guest made comfortable in room by writer and CNA (certified nursing assistant), RP at bedside ..." On 06/22/18 at 10:00 a.m., an interview was conducted with RN (registered nurse) # 1. When asked describe what documentation is provided to the receiving facility when a resident is transferred, RN # 1 stated, "The RP and physician are notified by phone, a bed hold policy is offered by nursing at the time of the transfer, and a transfer form is completed and sent with the resident." When asked if the resident and the RP are provided a written notification of the facility initiated transfer. RN # 1 stated, "No." Review of Resident # 64's clinical record failed to evidence documentation of written notification of the facility initiated transfer of Resident # 64 on 06/12/18.	F 623		

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On 06/22/18 at approximately 12:00 p.m., ASM (administrative staff member) # 1, administrator, ASM # 2, director of nursing were made aware of the above findings.

No further information was provided prior to exit.

References:
(1) The term "malignancy" refers to the presence of cancerous cells that have the ability to spread to other sites in the body (metastasize) or to invade nearby (locally) and destroy tissues. Malignant cells tend to have fast, uncontrolled growth and DO NOT die normally due to changes in their genetic makeup. Malignant cells that are resistant to treatment may return after all detectable traces of them have been removed or destroyed. . This information was obtained from the website: https://medlineplus.gov/ency/article/002253.htm.

(2) The larynx, or voice box, is located in the neck and performs several important functions in the body. The larynx is involved in swallowing, breathing, and voice production. Sound is produced when the air which passes through the vocal cords causes them to vibrate and create sound waves in the pharynx, nose and mouth. The pitch of sound is determined by the amount of tension on the vocal folds. This information was obtained from the website: https://medlineplus.gov/ency/imagepages/19708.htm.

(3) Stomach contents to leak back, or reflux, into the esophagus and irritate it. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/gerd.html.

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F 623	Continued From page 59 (4) Disease that makes it difficult to breath that can lead to shortness of breath). This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/copd.html. (5) A surgical procedure to create an opening through the neck into the trachea (windpipe). A tube is most often placed through this opening to provide an airway and to remove secretions from the lungs. This tube is called a tracheostomy tube or trach tube.. This information was obtained from the website: https://medlineplus.gov/ency/article/002955.htm. (6) An enlarged prostate. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/enlargedprostatebph.html.	F 623		
F 625 SS=E	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a	F 625		8/3/18

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F 625	Continued From page 60 resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, facility document review, and clinical record review, it was determined that facility staff failed to provide the written bed hold notification for a facility-initiated transfer for four of 32 residents in the survey sample, Resident #46, #50, #39, #64. 1. The facility staff failed to provide written documentation of bed hold to the Resident/Responsible Representative upon transfer to hospital for Resident #46 on 6/8/18. 2. The facility staff failed to provide written documentation of bed hold to the Resident/Responsible Representative upon transfer to hospital for Resident #50 on 3/9/18 and 4/6/18. 3. The facility staff failed to evidence that a written bed hold notification was provided to Resident #39 or the resident representative upon a transfer to the hospital on 4/19/18. 4. The facility staff failed to provide Resident # 64 or the resident's representative written notification of the bed hold policy when the resident was	F 625	Resident #46, #50, #39 and #64 have all returned to the facility to the bed/room they were in prior to transfer. All residents have the potential to be affected. Licensed nursing staff to be educated by DON/Designee to provide written bed hold notification to the resident and or their responsible party. DON/Designee during morning clinical meeting to conduct quality monitoring of transfers out of the facility to ensure written notification of the bed hold policy was given 5x week x1 weeks, then weekly x4, monthly, PRN and as indicated. Findings to be communicated to the QA committee monthly and as indicated. Quality monitoring schedules modified based on findings.	

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transferred to the hospital on 06/12/18.

The findings include:

1. Resident #46 was admitted to the facility on 6/9/14 and readmitted on 6/13/18 with diagnoses that included but were not limited to muscle weakness, urine retention, post stroke, acquired absence of other specified parts of digestive tract with a gastronomy (1) and jejunostomy tube (2), high blood pressure, and diabetes. Resident #46's most recent MDS (minimum data set) assessment was a 60 day scheduled assessment with an ARD (assessment reference date) of 5/9/18. Resident #46 was coded as being cognitively intact in the ability to make daily decisions scoring 12 out of possible 15 on the BIMS (Brief Interview for Mental Status) exam.

Review of Resident #46's clinical record revealed that he had gone out to the hospital on 6/8/18.

A SBAR (Situation, Background, Assessment and Recommendation) form dated 6/8/18, documented in part, the following: "Mental Status Evaluation: Decreased level of consciousness...Respiratory Evaluation: Cough, Productive...Abdominal Evaluation: Abdominal pain/tenderness/distended abdomen...Summarize your observations and evaluation: Please evaluate for possible abscess near the JTUBE (jejunostomy tube) site, fever, pain and copious foul smelling drainage. Primary Care Clinician Notified: (Name of NP (nurse practitioner) Date: 6/8/18 at 11:30 a.m., Recommendations of Primary Clinicians (if any): Send to ER (emergency room) for Evaluation."

Review of Nursing Home to Hospital Transfer

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form failed to evidence that a written bed hold policy was provided to the resident/resident representative upon transfer to the hospital on 6/8/18.

Further review of Resident #46's clinical record revealed that he was admitted back to the facility on 6/13/18 with a diagnosis of a UTI (urinary tract infection).

On 6/22/18 at 9:20 a.m., an interview was conducted with LPN (licensed practical nurse) #1. When asked the process of sending a resident out to the hospital, LPN #1 stated that she would first assess the resident to determine the need for transfer, notify the responsible party and MD (medical doctor), and then she would fill out a transfer form. When asked who was responsible for offering written notification of the bed hold policy, LPN #1 stated that the nurses are supposed to send the bed hold policy with the residents at the time of transfer. LPN #1 stated that nurses should be documenting that the bed hold policy was offered.

On 6/22/18 at 12:02 p.m., ASM #1, the administrator, ASM #2, the DON (Director of Nursing), and ASM #4, the Regional Director of Operations, were made aware of the above concerns. ASM (administrative staff member) #2, the DON (Director of Nursing) was asked to provide evidence that the written bed hold policy was offered to Resident #46.

On 6/22/18 at 1:26 p.m., an interview was conducted with OSM (Other staff member) #4, the Director of Admissions and Marketing. When asked about the process for offering the written bed hold policy at the time of a hospital transfer,

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OSM #4 stated that if a resident goes out to the hospital, nursing will send the bed hold policy with EMS (emergency medical services) at the time of transfer. OSM #4 stated that the next day admissions will call the family or speak with the responsible party regarding the bed hold. OSM #4 stated that she does not document this information in PCC because she does not have access to PCC (point click care). OSM #4 stated there was a separate form that the admission office completes when they ask the family about the bed hold. When asked how to determine if nursing sent the written bed hold notice to the hospital at the time of transfer with EMS for the resident or family, OSM #4 stated, "Personally, I do not know the answer."

Evidence of written bed hold notification given to Resident #46 could not be provided prior to exit.

The facility policy titled, "Bed Hold and Return to Facility" documents in part, the following: "The facility will provide written information to the guest or guest's representative of this bed hold policy upon leaving for hospitalization or a therapeutic leave."

(1) Gastronomy- A percutaneous endoscopic gastronomy tube can be used to deliver nutrition, hydration and medicines directly into the patient's stomach. Patients will require a tube if they are unable to swallow safely, putting them at risk of aspiration of food, drink and medicines into their lungs. This information was obtained from The National Institutes of Health. https://www.ncbi.nlm.nih.gov/pubmed/26016095.

(2) Jejunostomy allows a feeding tube to be put into the small intestine. This information was

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obtained from The National Institutes of Health. https://www.cancer.gov/publications/dictionaries/cancer-terms/def/jejunostomy.

2. The facility staff failed to provide written documentation of bed hold to the Resident/Responsible Representative upon transfer to hospital for Resident #50 on 3/9/18 and 4/6/18.

Resident #50 was admitted to the facility on 1/6/14 and readmitted on 4/13/18 with diagnoses that included but were not limited to type two diabetes, atrial fibrillation, heart failure, and high blood pressure. Resident #50's most recent MDS (minimum data set) assessment was an annual assessment with an ARD (assessment reference date) of 5/7/18. Resident #50 was coded as being cognitively intact in the ability to make daily decisions, scoring 12 out of 15 on the BIMS (Brief Interview for Mental Status) Exam. Resident #50 was coded as requiring extensive assistance with one staff member for bed mobility, toileting, and personal hygiene; and extensive assistance from two plus staff members for transfers.

Review of Resident #50's clinical record revealed that she had first been transferred to the hospital on 3/9/18 due to a fall. The following was documented: "Found on floor next to bed on R (right) side at 4:05 p.m. No neuro changes noted. Pulse is 124 RR (respirations) is 24 BP (blood pressure) is 134/92. Unable to extend R leg in bed, c/o (complained) pain in hip area. Physician notified and order received to send guest out at 4:10 p.m. Daughter (Name of daughter), notified,and requests (Name of hospital). Transported at this time to (Name of hospital) via

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(Name of EMT Service). "

The next note dated 3/9/18 documented the following: "Interfacility transfer sheet, copy of current orders, copy of code sheet and face sheet sent with squad for ER (emergency room) at (Name of hospital)."

There was no evidence that the written bed hold policy was provided to the resident/resident representative upon transfer to the hospital on 3/9/18.

Review of Resident #50's nursing notes revealed that she arrived back to the facility on 3/13/18 with a diagnosis of a hip fracture and post surgical repair.

Further review of Resident #50's clinical record revealed she was transferred to the hospital for the second time on 4/6/18. The following was documented: "Blood Sugar at 4:45 pm 70 and taken in R (right) hand. Guest is drowsy. CNA (certified nursing assistant) enters room for VS (vital signs) at 5 pm and guest is unresponsive with VS and FSBS (fasting blood sugar) of 22 at 5:05 p.m. Cool H20 (water) and washcloths used to attempt to get verbal response without success. At 5:10 p.m., blood sugar at 32 with Glucagon (1) given and 911 called from nurses station per staff. Pulse is 102, RR (respiratory rate) 16, BP (blood pressure) 134/82 manually. Attempt made to call daughter from guests portable phone in room at this time unsuccessful, no answer, EMTs (emergency medical technicians) arrived at 5:15 p.m. with report given verbally with vital signs and blood glucose results written. DON (Director of Nursing) texted at this time with information and message left on on-call

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physician's emergency number for (Name or physician) at this time."

There was no evidence that the written bed hold policy was provided to the resident/resident representative upon transfer to the hospital on 4/6/18.

Further review of Resident #50's clinical record revealed that Resident #50 returned to the facility on 4/13/18.

On 6/22/18 at 9:20 a.m., an interview was conducted with LPN (licensed practical nurse) #1. When asked the process of sending a resident out to the hospital, LPN #1 stated that she would first assess the resident to determine the need for transfer, notify the responsible party and MD (medical doctor), and then she would fill out a transfer form. When asked who was responsible for offering written notification of the bed hold policy, LPN #1 stated that the nurses are supposed to send the bed hold policy with the residents at the time of transfer. LPN #1 stated that nurses should be documenting that the bed hold policy was offered.

On 6/22/18 at 12:02 p.m., ASM #1, the administrator, ASM #2, the DON (Director of Nursing), and ASM #4, the Regional Director of Operations, were made aware of the above concerns. ASM (administrative staff member) #2, the DON (Director of Nursing) was asked to provide evidence that the written bed hold policy was offered to Resident #50.

On 6/22/18 at 1:26 p.m., an interview was conducted with OSM (Other staff member) #4, the Director of Admissions and Marketing. When

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asked about the process for offering the written bed hold policy at the time of a hospital transfer, OSM #4 stated that if a resident goes out to the hospital, nursing will send the bed hold policy with EMS (emergency medical services) at the time of transfer. OSM #4 stated that the next day admissions will call the family or speak with the responsible party regarding the bed hold. OSM #4 stated that she does not document this information in PCC because she does not have access to PCC (point click care). OSM #4 stated there was a separate form that the admission office completes when they ask the family about the bed hold. When asked how to determine if nursing sent the written bed hold notice to the hospital at the time of transfer with EMS for the resident or family, OSM #4 stated, "Personally, I do not know the answer."

Evidence of written bed hold notification given to Resident #50 could not be provided prior to exit.

(1) Glucagon injection is an emergency medicine used to treat severe hypoglycemia (low blood sugar) in diabetes patients. This information was obtained from The National Institutes of Health. https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0010481/?report=details.

3. The facility staff failed to evidence that a written bed hold notification was provided to Resident #39 or the resident representative upon a transfer to the hospital on 4/19/18.

Resident #39 was admitted to the facility on 6/13/17 and readmitted on 4/26/18 after a brief hospitalization, with the diagnoses of but not limited to stroke, hemiplegia, Parkinson's

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disease, diabetes, anxiety disorder, benign prostatic hyperplasia, dementia, dysphagia, spinal stenosis, high blood pressure, osteoarthritis, alcohol abuse, and atrial fibrillation. The most recent MDS (Minimum Data Set) was a significant change assessment with an ARD (Assessment Reference Date) of 5/4/18. The resident was coded as severely cognitively impaired in ability to make daily life decisions.

A review of the clinical record revealed that the resident went to the hospital on 4/19/18. A review of the nurse's notes failed to reveal any date for when the resident went to the hospital.

A review of the "Nursing Home to Hospital Transfer Form" did not reveal an area specifically designating that the bed hold was sent and there was no documented evidence that one was sent on 4/19/18.

On 6/22/18 at 9:51 a.m., in an interview with OSM #1 (Other Staff Member, the social worker), she stated that she is not involved in any capacity when a resident is transferred to the hospital.

On 6/22/18 at 10:02 AM, in an interview with RN #1 (Registered Nurse), when asked about bed holds, RN #1 stated the bed hold should be offered as part of the transfer packet. When asked if it is documented anywhere, RN #1 stated, "It should be."

A review of the facility policy, "Bed Hold and Return to the Facility" documented, "The facility will provide written information to the guest or guest's representative of this bed hold policy upon leaving for hospitalization or a therapeutic leave."

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On 6/22/18 at 12:30 PM, ASM #1 (Administrative Staff Member, the Administrator) and ASM #2 (the Director of Nursing) were made aware of the findings.

No further information was provided by the end of the survey.

4. The facility staff failed to provide Resident # 64 or the resident's representative written notification of the bed hold policy when the resident was transferred to the hospital on 06/12/18.

Resident # 64's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 05/18/18, coded Resident # 64 as scoring a 14 on the brief interview for mental status (BIMS) of a score of 0 - 15, 14 - being cognitively intact for making daily decisions.

The nurse's "Progress Notes" for Resident # 64 dated 06/12/18 documented, "22:30 (10:22 p.m.) Following up from previous shift. Guest lab (laboratory) results critical. N.O. (new order) from MD (medical doctor, Name of Physician) to send guest to (Name of Hospital) for further evaluation. RP (responsible party) notified. (Name of RP) wanted to transport guest. Guest sent out via (by) w/c (wheelchair) accompanied by RP to (Name of Hospital)."

The nurse's "Progress Notes" for Resident # 64 dated 06/13/18 documented in part, "19:313 (7:13 p.m.) Guest arrived via w/c from (Name of Hospital) accompanied by RP (Name of RP). Guest made comfortable in room by writer and CNA (certified nursing assistant), RP at bedside

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On 06/22/18 at 10:00 a.m., an interview was conducted with RN (registered nurse) # 1. When asked describe what documentation is provided to the receiving facility when a resident is transferred RN # 1 stated, "The RP and physician are notified by phone, a bed hold policy is offered by nursing at the time of the transfer, and a transfer form is completed and sent with the resident."

On 06/22/18 at 1:25 p.m., an interview was conducted with OSM (other staff member) # 4, director of admissions and marketing. When asked about the process of providing a bed hold policy at the time a resident is transferred to the hospital, OSM # 4 stated, "When a resident is transferred to the hospital, nursing calls the family, the bed hold policy is sent with the resident at the time of the transfer. The bed hold policy is attached to the transfer form and is sent with the resident."

On 06/22/18 at 2:45 p.m., an interview was conducted with ASM (administrative staff member) # 2, director of nursing. When asked if a bed hold policy was provided to Resident # 64 or Resident # 64's responsible party at the time of the transfer to the hospital on 06/12/18, ASM # 2 stated, "No."

On 06/22/18 at approximately 12:00 p.m., ASM (administrative staff member) # 1, administrator, ASM # 2, director of nursing were made aware of the above findings.

No further information was provided prior to exit.

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References:
(1) The term "malignancy" refers to the presence of cancerous cells that have the ability to spread to other sites in the body (metastasize) or to invade nearby (locally) and destroy tissues. Malignant cells tend to have fast, uncontrolled growth and DO NOT die normally due to changes in their genetic makeup. Malignant cells that are resistant to treatment may return after all detectable traces of them have been removed or destroyed. . This information was obtained from the website: https://medlineplus.gov/ency/article/002253.htm.

(2) The larynx, or voice box, is located in the neck and performs several important functions in the body. The larynx is involved in swallowing, breathing, and voice production. Sound is produced when the air which passes through the vocal cords causes them to vibrate and create sound waves in the pharynx, nose and mouth. The pitch of sound is determined by the amount of tension on the vocal folds. This information was obtained from the website: https://medlineplus.gov/ency/imagepages/19708.htm.

(3) Stomach contents to leak back, or reflux, into the esophagus and irritate it. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/gerd.html.

(4) Disease that makes it difficult to breath that can lead to shortness of breath). This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/copd.html.

(5) A surgical procedure to create an opening through the neck into the trachea (windpipe). A

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F 625	Continued From page 72 tube is most often placed through this opening to provide an airway and to remove secretions from the lungs. This tube is called a tracheostomy tube or trach tube.. This information was obtained from the website: https://medlineplus.gov/ency/article/002955.htm. (6) An enlarged prostate. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/enlargedprostatebph.html.	F 625		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record, it was determined that the facility staff failed to maintain an accurate MDS (minimum data set) assessment for one of 32 residents in the survey sample, Resident # 81. The facility staff failed to accurately code Resident # 81's MDS (minimum data set), a quarterly assessment, with an ARD (assessment reference date) of 05/23/18, for safety devices. The findings include: Resident # 81 was admitted to the facility on 06/24/09 with a readmission of 03/30/11 with diagnoses that included but were not limited to Alzheimer's disease (1) hypertension (2), diabetes mellitus (3), depressive disorder (4),	F 641	Resident #81s MDS has been coded correctly. A quality review of the MDS of guests with safety devices has been performed. The MDS coordinator/designee to educate MDS Nurses on accurate MDS documentation. The MDS coordinator/designee during morning clinical meeting to conduct quality monitoring of MDS accuracy 5x week x1 week, weekly x4 weeks and then monthly, PRN and as indicated. Findings to be communicated to the QA committee monthly and as indicated. Quality monitoring schedules modified based on findings.	8/3/18

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anxiety (5) and anemia (6).

Resident # 81's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 05/23/18, coded Resident # 81 as scoring a 3 (three) on the brief interview for mental status (BIMS) of a score of 0 - 15, 3 (three) - being severely impaired of cognition intact for making daily decisions. Resident # 81 was coded as requiring extensive assistance of one staff member for activities of daily living. Review of section "P0200 Alarms" revealed it was coded as zeros for "A. bed alarm and F. Other alarm."

The physician's orders for Resident # 81 dated 04/01/2018 documented, "Alarming self-releasing seat belt while in wheel chair. Start Date: 01/10/2018." "Sensor pad alarm to bed. Start Date: 01/10/2018."

The eTAR (electronic treatment administration record) for Resident # 81 dated June 2018 documented,
"Alarming self-releasing seat belt while in wheel chair. Start Date: 01/10/2018."
"Sensor pad alarm to bed. Start Date: 01/10/2018."

On 06/22/18 at 11:10 a.m., an interview was conducted with RN (registered nurse) # 5 regarding section "P0200 Alarms" of Resident # 81's quarterly MDS assessment with an ARD of 05/23/18. After reviewing the MDS assessment, RN # 5 stated, "(Resident # 81) should have been coded for the bed alarm and the alarming belt. It was an oversight." When asked what guidance they use for completing the MDS, RN # 5 stated, "The RAI resident assessment instrument)

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manual."

The "Resident Assessment Instrument 3.0 User's Manual Version 1.15 October 2017" documented, Alarms. Item Rationale. Health-related Quality of Life
o An alarm is any physical or electronic device that monitors resident movement and alerts the staff, by either audible or inaudible means, when movement is detected, and may include bed, chair and floor sensor pads, cords that clip to the resident's clothing, motion sensors, door alarms, or elopement/wandering devices.
o While often used as an intervention in a resident's fall prevention strategy, the efficacy of alarms to prevent falls has not been proven; therefore, alarm use must not be the primary or sole intervention in the plan.
o The use of an alarm as part of the resident's plan of care does not eliminate the need for adequate supervision, nor does the alarm replace individualized, person-centered care planning.
o Adverse consequences of alarm use include, but are not limited to, fear, anxiety, or agitation related to the alarm sound; decreased mobility; sleep disturbances; and infringement on freedom of movement, dignity, and privacy.
Steps for Assessment
1. Review the resident's medical record (e.g., physician orders, nurses' notes, nursing assistant documentation) to determine if alarms were used during the 7-day look-back period.
2. Consult the nursing staff to determine the resident's cognitive and physical status/limitations.
3. Evaluate whether the alarm affects the resident's freedom of movement when the alarm/device is in place. For example, does the resident avoid standing up or repositioning

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himself/herself due to fear of setting off the alarm?

On 06/22/18 at approximately 12:00 p.m., ASM (administrative staff member) # 1, administrator, ASM # 2, director of nursing were made aware of the above findings.

No further information was provided prior to exit.

References:
(1) A brain disorder that seriously affects a person's ability to carry out daily activities). This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/alzheimersdisease.html.

(2) High blood pressure. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/highbloodpressure.html.

(3) A chronic disease in which the body cannot regulate the amount of sugar in the blood. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/ency/article/001214.htm.

(4) Depression may be described as feeling sad, blue, unhappy, miserable, or down in the dumps. Most of us feel this way at one time or another for short periods. Clinical depression is a mood disorder in which feelings of sadness, loss, anger, or frustration interfere with everyday life for weeks or more. This information was obtained from the website: https://medlineplus.gov/ency/article/003213.htm.

(5) Fear. This information was obtained from the

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F 641	Continued From page 76 website: https://www.nlm.nih.gov/medlineplus/anxiety.html #summary. (6) Low iron. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/anemia.html .	F 641		
F 656 SS=E	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the	F 656		8/3/18

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F 656	Continued From page 77 resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on staff interview, resident interview, facility document review and clinical record review, it was determined that the facility staff failed to follow/implement the care plan for nine of 32 residents in the survey sample, Resident #s 102, 37, 64, 6, 50, 74, 311, 108 and 23. 1. The facility staff failed to follow/implement the comprehensive care plan for Resident # 102's fluid restriction. 2. The facility staff failed to follow Resident # 37's comprehensive care plan for implementing non-pharmacological interventions for pain. 3. The facility staff failed to follow/implement Resident # 64's care plan for the administration of oxygen. 4a. The facility staff failed to obtain daily weights for Resident #6, per the physician's orders and the comprehensive care plan. 4b. The facility staff failed to obtain weights for	F 656	Resident #102 care plan for fluid restriction has been updated. Resident #37 comprehensive care plan has been updated to include non-pharmacological interventions. Resident #64 comprehensive care plan for oxygen has been updated. Resident's #6 weights are being obtained as per Physician orders. Resident #50 fall mat is in place as per care plan. Resident#74 no longer resides in the facility. Resident #108 medications are being administered as per Physician order. Resident #23 care plan is being followed for fluid restrictions. Resident #311 weights are being observed as per Physician order. All residents have the potential to be affected. DON/Designee to educate MDS Nurses on updating comprehensive care plans, DON/designee to re-educate Nursing staff on obtaining weights as per Physician orders, DON/designee to educate Nursing	

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F 656	Continued From page 78 Resident #6, prior to dialysis per the physician's orders and the comprehensive care plan. 5. The facility staff failed to ensure a fall mat was in place per the comprehensive plan of care for Resident #50. 6. The facility staff failed to follow the comprehensive care plan for obtaining physician ordered daily weights for Resident #74. 7. The facility staff failed to follow the comprehensive care plan to obtain daily weights for Resident #311. 8. The facility staff failed to follow the comprehensive care plan to administer medications as ordered for diabetes for Resident #108. 9. The facility staff failed to follow Resident #23's comprehensive care plan for fluid restrictions. The findings include: 1. The facility staff failed to follow/implement the comprehensive care plan for Resident # 102's fluid restriction. Resident # 102 was admitted to the facility on 02/10/15 with a readmission of 11/30/17 with diagnoses that included but were not limited to respiratory failure (1) diabetes mellitus (2), gastroesophageal reflux disease (3), depressive disorder (4), anxiety (5) and anemia (6). Resident # 102's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 06/01/18, coded	F 656	staff on ensuring care plans are being followed for fall interventions, DON/designee to educate Nursing staff regarding following Physician orders for medication administration and fluid restrictions. Don/designee during Morning Clinical Meeting to conduct quality monitoring 5x week x1 week, weekly x4 and then monthly, PRN and indicated. Findings to be communicated to the QA committee monthly and as indicated. Quality monitoring schedules modified based on findings.	

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Resident # 102 as scoring a 14 on the brief interview for mental status (BIMS) of a score of 0 - 15, 14 - being cognitively intact for making daily decisions. Resident # 102 was coded as being independent and requiring the assistance of one staff member for activities of daily living.

The physician's orders for Resident # 102 dated 11/30/2017 to 06/30/2018 documented, "1800cc (cubic centimeters)/day. Fluid restriction. Nursing to provide 300 ml (milliliters) on Day shift, 300 ml on Eve (evening) shift, 120 ml on Night shift. Start Date: 05/25/2018."

The eMAR (electronic medication administration record) for Resident # 102 dated June 2018 failed to evidence the amount of fluid Resident # 102 received during the day shift on 06/18/18.

The comprehensive care plan for Resident # 102 dated 03/27/2018 documented, "Need. FLUID: Potential for dehydration related to: Diuretic use, fluid restriction and Dx (diagnoses) of Cirrhosis, HTN (hypertension), DM (diabetes mellitus), thrombocytopenia, metabolic encephalopathy, Gerd, and H/O (history of) irritable bowel. Date initiated: 03/27/2018." Under "Interventions" it documented, "Fluid restrictions as ordered."

On 06/21/18 at 2:20 p.m., an interview was conducted with LPN (licensed practical nurse) # 2. After reviewing the eMAR for Resident # 102 dated June 2018 for the day shift on 06/18/18 LPN # 2 was asked about the lack of documentation. LPN # 2 stated, "There is no way to tell how much she was given. We would not know if they exceeded the amount if it's not documented." LPN #2 stated, "It could be

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documented in the nurse's notes, but if it isn't, can't tell how they had." LPN # 2 reviewed the nurse's progress notes for Resident # 102 dated 06/01/18 through 06/18/18. LPN # 2 stated the fluid intake for the day shift on 06/18/18 was not documented. When asked why it was important to document a resident's fluid intake LPN # 2 stated, "If they have too much fluid it could put them into congestive heart failure or throw off their electrolytes."

On 06/22/18 at 10:55 a.m., an interview was conducted with LPN # 9. When asked to describe the purpose of a care plan LPN # 9 stated, "It's an outline of what care the resident needs." When asked about following the care plan LPN # 9 stated, "If it's on the care plan it should be followed." When asked about Resident # 102's missing fluid intake on 06/18/18, LPN # 9 stated the care plan was not followed.

On 06/22/18 at approximately 12:00 p.m., ASM (administrative staff member) # 1, administrator, ASM # 2, director of nursing were made aware of the above findings.

No further information was provided prior to exit.

References:
(1) A long-term disease. It leads to inflammation of the joints and surrounding tissues. It can also affect other organs. This information was obtained from the website: https://medlineplus.gov/ency/article/000431.htm.

(2) A chronic disease in which the body cannot regulate the amount of sugar in the blood. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/ency/article/

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001214.htm.

(3) Stomach contents to leak back, or reflux, into the esophagus and irritate it. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/gerd.html.

(4) Depression may be described as feeling sad, blue, unhappy, miserable, or down in the dumps. Most of us feel this way at one time or another for short periods. Clinical depression is a mood disorder in which feelings of sadness, loss, anger, or frustration interfere with everyday life for weeks or more. This information was obtained from the website: https://medlineplus.gov/ency/article/003213.htm.

(5) Fear. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/anxiety.html #summary.

(6) Low iron. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/anemia.html .

2. The facility staff failed to follow Resident # 37's comprehensive care plan for implementing non-pharmacological interventions for pain.

Resident # 37 was admitted to the facility on 10/15/17 with a readmission of 04/03/18 with diagnoses that included but were not limited to peripheral vascular disease (1) diabetes mellitus (2), chronic kidney disease (3), depressive disorder (4), anxiety (5) and anemia (6).

Resident # 37's most recent MDS (minimum data

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set), a quarterly assessment with an ARD (assessment reference date) of 04/24/18, coded Resident # 37 as scoring a 10 on the brief interview for mental status (BIMS) of a score of 0 - 15, 10 - being moderately impaired of cognition intact for making daily decisions.

The physician's orders for Resident # 37 dated 04/01/2018 documented, "Norco (7) Tablet. 7.5-325 MG (milligram) (Hydrocodone-Acetaminophen). Give 1 (one) tablet by mouth every 6 (six) hours as needed for pain max (maximum) daily amount 4 (four) tab (tablets)."

The EMAR (electronic medication administration record) for Resident # 37 dated April 2018 documented the above physician's orders. Further review of the EMAR revealed the Norco Tablet. 7.5-325 MG was administered as follows:
On 04/06/18 at 9:20 a.m., with a pain level of 4 (four).
On 04/07/18 at 1532 (3:32 p.m.) with a pain level of 9 (nine) and at 2141 (9:41 p.m.) with a pain level of 9 (nine).
On 04/08/18 at 9:10 a.m. with a pain level of 9 (nine), at 1615 (4:16 p.m.) with a pain level of 8 (eight) and at 2232 (10:32 p.m.) with a pain level of 8 (eight).
On 04/09/18 at 2057 (8:57 p.m.) with a pain level of 3 (three).
On 04/13/18 at 1306 (1:06 p.m.) with a pain level of 6 (six).
On 04/14/18 at 11:06 a.m. with a pain level of 6 (six) and at 2017 (8:17 p.m.) with a pain level of 3 (three).
On 04/ 15/18 at 5:12 a.m., with a pain level of 8 (eight).
On 04/16/18 at 5:28 a.m., with a pain level of 7

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(seven).
On 04/18 /18 at 2033 (8:33 p.m.) with a pain level of 3 (three).
On 04/21/18 at 8:55 a.m., with a pain level of 4 (four) and at 1714 (5:14 p.m.) with a pain level of 5 (five).
On 04/22/18 at 8:12 a.m., with a pain level of 3 (three) and at 1815 (6:15 p.m.) with a pain level of 8 (eight).
On 04/28/18 at 1:06 a.m., with a pain level of 4 (four).
On 04/30/18 at 1709 (5:09 p.m.) with a pain level of 6 (six).

The EMAR (electronic medication administration record) for Resident # 37 dated May 2018 documented the above physician's order. Further review of the EMAR revealed the Norco Tablet. 7.5-325 MG was administered as follows:
On 05/05/18 at 1806 (6:06 p.m.) with a pain level of 4 (four).
On 05/06/18 at 1739 (5:39 p.m.) with a pain level of 5 (five).
On 05 14/18/18 at 9:08 a.m. with a pain level of 6 (six).
On 05/15/18 at 10:22 a.m. with a pain level of 5 (five).
On 05/18/18 at 9:08 a.m.) with a pain level of 6 (six).
On 05/19/18 at 1735 (5:53 p.m. with a pain level of 5 (five).
On 05/20/18 at 8:23 a.m. with a pain level of 3 (three) and at 1815 (6:18 p.m.) with a pain level of 6 (six).

The EMAR (electronic medication administration record) for Resident # 37 dated June 2018 documented the above physician's order. Further review of the EMAR revealed the Norco Tablet.

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7.5-325 MG was administered on 06/18/18 at 9:25 a.m., with a pain level of 4 (four).

The comprehensive care plan for Resident # 37 dated 04/04/2018 documented, "Need. Potential for pain r/t (related to): AKA (above the knee amputation) and right BKA (below the knee amputation), H/O (history of) CVA (cerebral vascular accident) [stroke], with right hemiparesis, CKD (chronic kidney disease), Diabetes, neuropathy, HTN, hyperlipidemia, CAD (coronary artery disease), anemia, PVD (peripheral vascular disease) Vertigo, Retinopathy. Date initiated: 04/04/2018." Under "Interventions" it documented, "Assist to position for comfort with physical support as necessary. Date initiated: 04/04/2018."

Review of the nurse's progress notes dated 04/06/18 through 06/18/18 failed to evidence documentation of non- pharmacological interventions prior to the use of Norco 7.5-325 mg tablet.

On 06/22/18 at 10:55 a.m., an interview was conducted with LPN (licensed practical nurse) # 9. When asked to describe the purpose of a care plan, LPN # 9 stated, "It's an outline of what care the resident needs." When asked about following the care plan, LPN # 9 stated, "If it's on the care plan it should be followed." When asked about Resident # 37's comprehensive care plan documenting "Assist to position for comfort with physical support as necessary", LPN # 9 stated the care plan was not followed.

On 06/22/18 at approximately 12:00 p.m., ASM (administrative staff member) # 1, administrator, ASM # 2, director of nursing were made aware of

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the above findings.

No further information was provided prior to exit.

References:
(1) The vascular system is the body's network of blood vessels. It includes the arteries, veins and capillaries that carry blood to and from the heart. Arteries can become thick and stiff, a problem called atherosclerosis. Blood clots can clog vessels and block blood flow to the heart or brain. Weakened blood vessels can burst, causing bleeding inside the body.) This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/vasculardiseases.html.

(2) A chronic disease in which the body cannot regulate the amount of sugar in the blood. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/ency/article/001214.htm.

(3) Kidneys are damaged and can't filter blood as they should. This information was obtained from the website: https://medlineplus.gov/chronickidneydisease.html.

(4) Depression may be described as feeling sad, blue, unhappy, miserable, or down in the dumps. Most of us feel this way at one time or another for short periods. Clinical depression is a mood disorder in which feelings of sadness, loss, anger, or frustration interfere with everyday life for weeks or more. This information was obtained from the website: https://medlineplus.gov/ency/article/003213.htm.

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(5) Fear. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/anxiety.html #summary.

(6) Low iron. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/anemia.html .

(7) Hydrocodone is an opioid pain medication. An opioid is sometimes called a narcotic. Acetaminophen is a less potent pain reliever that increases the effects of hydrocodone. The combination of acetaminophen and hydrocodone is used to relieve moderate to severe pain. This information was obtained from the website: https://www.rxlist.com/norco-5-325-drug/patient-images-side-effects.htm.

3. The facility staff failed to follow Resident # 64's care plan for the administration of oxygen.

Resident # 64 was admitted to the facility on 02/14/18 with a readmission of 03/13/18 with diagnoses that included but were not limited to malignant neoplasm (1) of the larynx (2), gastroesophageal reflux disease (3), chronic obstructive pulmonary disease (4), tracheostomy (5) and benign prostatic hyperplasia (6).

Resident # 64's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 05/18/18, coded Resident # 64 as scoring a 14 on the brief interview for mental status (BIMS) of a score of 0 - 15, 14 - being cognitively intact for making daily decisions. Resident # 64 was coded as requiring

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extensive assistance of one staff member for activities of daily living. Under section "O. Special Treatment, Procedures and Programs" Resident # 64 was coded for "C. Oxygen therapy and E. Tracheostomy care."

An observation on 06/19/18 at approximately 6:00 p.m., revealed Resident # 64 was in bed receiving oxygen from an oxygen concentrator via a tracheostomy tube. Observation of the flow mete on the O2 (oxygen) concentrator revealed three and a half liter per minute.

An observation on 06/20/18 at 12:45 p.m., revealed Resident # 64, sitting up in bed, watching television, receiving oxygen from an oxygen concentrator via a tracheostomy tube. Observation of the flow mete on the O2 (oxygen) concentrator revealed three and a half liter per minute.

An observation on 06/20/18 at 12:53 p.m., revealed a nurse entered resident # 64's room per his request and closed the door. An observation on at 12:54 p.m., revealed Resident # 64, sitting up in bed, watching television, receiving oxygen from an oxygen concentrator via a tracheostomy tube. Observation of the flow mete on the O2 (oxygen) concentrator revealed three and a half liter per minute.

An observation on 06/21/18 at 10:55 a.m., revealed Resident # 64, sitting up in bed, watching television, receiving oxygen from an oxygen concentrator via a tracheostomy tube. Observation of the flow mete on the O2 (oxygen) concentrator revealed three and a half liter per minute.

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The physician's orders for Resident # 64 dated 03/03/2018 through 06/30/18 documented, "Oxygen 5 (five) l/min (liters per minute) via trach (tracheostomy) every shift. Order Date: 03/13/2018. Start Date: 03/13/2018."

The EMAR (electronic medication administration record) dated June 2018 for Resident # 64 documented, Oxygen 5 (five) l/min (liters per minute) via trach (tracheostomy) every shift. Start Date: 03/13/2018." Further review of the EMAR documented Resident # 64 received oxygen by tracheostomy on 06/19/18, 06/20/18 and on 06/21/18.

The comprehensive care plan for Resident # 64 dated 03/14/18 documented, "Need. Potential difficulty Breathing R/T (related to): SOB (shortness of breath), abnormal respiration, abnormal pulse, oximetry,..R/T cardiac condition, (HTN [hypertension], COPD [chronic obstructive pulmonary disease], Tracheostomy, Cancer, squamous cell cancer of lung). Date initiated: 03/14/2018." Under "Interventions" it documented, "Administer medication & (and) treatment per physician's order. Monitor for effectiveness, side effects and adverse reactions of medications and treatments and report abnormal findings to physician. Oxygen, Pulse Oximetry, Suction, trach (tracheostomy) care, elevate HOB (head of bed)."

On 06/22/18 at 10:55 a.m., an interview was conducted with LPN # 9. When asked to describe the purpose of a care plan LPN # 9 stated, "It's an outline of what care the resident needs." When asked about following the care plan LPN # 9 stated, "If it's on the care plan it should be followed." When asked about Resident

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64's oxygen being observed at the wrong flow rate and the care plan documenting "Administer medication & (and) treatment per physician's order. Monitor for effectiveness, side effects and adverse reactions of medications and treatments and report abnormal findings to physician. Oxygen, Pulse Oximetry, Suction, trach (tracheostomy) care, elevate HOB (head of bed)", LPN # 9 stated the care plan was not followed.

On 06/22/18 at approximately 12:00 p.m., ASM (administrative staff member) # 1, administrator, ASM # 2, director of nursing were made aware of the above findings.

No further information was provided prior to exit.

References:
(1) The term "malignancy" refers to the presence of cancerous cells that have the ability to spread to other sites in the body (metastasize) or to invade nearby (locally) and destroy tissues. Malignant cells tend to have fast, uncontrolled growth and DO NOT die normally due to changes in their genetic makeup. Malignant cells that are resistant to treatment may return after all detectable traces of them have been removed or destroyed. . This information was obtained from the website:
https://medlineplus.gov/ency/article/002253.htm.

(2) The larynx, or voice box, is located in the neck and performs several important functions in the body. The larynx is involved in swallowing, breathing, and voice production. Sound is produced when the air which passes through the vocal cords causes them to vibrate and create sound waves in the pharynx, nose and mouth. The pitch of sound is determined by the amount

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of tension on the vocal folds. This information was obtained from the website: https://medlineplus.gov/ency/imagepages/19708.htm.

(3) Stomach contents to leak back, or reflux, into the esophagus and irritate it. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/gerd.html.

(4) Disease that makes it difficult to breath that can lead to shortness of breath). This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/copd.html.

(5) A surgical procedure to create an opening through the neck into the trachea (windpipe). A tube is most often placed through this opening to provide an airway and to remove secretions from the lungs. This tube is called a tracheostomy tube or trach tube.. This information was obtained from the website: https://medlineplus.gov/ency/article/002955.htm.

(6) An enlarged prostate. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/enlargedprostatebph.html.

4a. The facility staff failed to obtain daily weights for Resident #6, per the physician's orders and the comprehensive care plan.

Resident #6 was admitted to the facility on 12/6/17 with diagnoses that included but were not limited to end stage renal disease, heart failure, type two diabetes and COPD (chronic obstructive pulmonary disease). Resident #6's most recent MDS (minimum data set) assessment was a

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quarterly assessment with an ARD (assessment reference date) of 3/5/18. Resident #6's was coded as being cognitively intact in the ability to make daily decisions scoring 15 out of possible 15 on the BIMS (Brief Interview for Mental Status) exam.

Review of Resident #6's POS (physician order summary) dated 6/1/18, documented the following order: "Daily Weights- obtain and record- report gain of > (greater) than 3 pounds in 24 hours or < (less than) 5 lbs (pounds) in one week one time a day for heart failure." This order was initiated on 4/13/18.

Review of June 2018 MAR (medication Administration Record) for Resident #6, revealed check marks, indicating a weight was obtained, on the following days: 6/2/18, 6/4/18, 6/5/18, 6/6/18, 6/7/18, 6/9/18, 6/10/18, 6/12/18, 6/14/18, 6/17/18, 6/18/18, 6/19/18 and 6/21/18.

The daily weight recordings could not be found in the clinical record for to following dates: 6/2/18, 6/4/18, 6/9/18, 6/10/18, 6/12/18, 6/14/18, 6/17/18, and 6/21/18.

Further review of the June 2018 MAR revealed a weight was not obtained on 6/8/18, 6/11/18, and 6/15/18. The following was documented: "Absent from home." Review of the clinical record revealed Resident #6 was at dialysis on these dates. A weight should have been obtained per another physician's order to check weight prior to dialysis.

The June 2018 MAR also revealed a hole or blank space for 6/13/18. There was no note indicating why a weight was not obtained.

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Lastly, the June 2018 MAR documented the following for 6/20/18: "Hold/See nurses note." A note could not be found indicating why this weight was not obtained for this date.

Review of Resident #6's cardiac care plan dated 3/19/18 did not address obtaining daily weights. Resident #6's renal care plan dated 3/19/18 documented the following intervention: "Obtain daily weights as well as prior to dialysis sessions."

On 6/21/18 at 12:00 p.m., an interview was conducted with Resident #6. Resident #6 stated that the facility staff checked his weight about 50 percent of the time.

On 6/21/18 at 12:31 p.m., an interview was conducted with LPN (licensed practical nurse) #2, Resident #6's nurse that shift. LPN #2 stated daily weights were conducted on day shift. LPN #2 stated if weights could not be found in PCC (point click care), they may be in the daily weight book on the unit. This writer checked the daily weight book with LPN #2 for the above dates. Weights for Resident #6 were blank. LPN #2 stated it appeared that daily weights were not being completed. When asked if this was following the physician order and the comprehensive care plan, LPN #2 stated, it was not. LPN #2 could not determine why some weights were missing from the vital signs section in PCC and in the weight book. LPN #2 then stated the weights may have been done but not charted. LPN #2 confirmed she was the nurse who worked with Resident #6 on 6/20/18. LPN #2 could not recall why she documented "Hold/See nurses note" on the June MAR for 6/20/18. LPN #2 stated she has only worked with Resident #6 for a few days. LPN #2

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stated that she was new to the facility.

On 6/21/18 at 5:05 p.m., an interview was conducted with LPN #3, the unit manager. When asked the purpose of the comprehensive care plan, LPN #3 stated that the purpose of the care plan was to identify resident limitations, needs, goals, and provide a guide to care. RN #1 stated that all members of the IDT (interdisciplinary team) had access to the care plan. LPN#3 stated that the care plan should be followed unless the care plan was out of date. LPN #3 stated that it was important for the care plan to be accurate.

On 6/22/18 at 8:20 a.m., an interview was conducted with CNA (certified nursing assistant) #1. When asked who was responsible for weighing residents, CNA #1 stated that two aides and one nurse will weigh a resident together and the nurse will record the weight. CNA #1 stated that she did not work with Resident #6.

On 6/22/18 at 9:20 a.m., an interview was conducted by telephone with LPN #1, a nurse who signed off on the MAR that a daily weight was obtained on 6/9/18 and 6/10/18 for Resident #6. When asked the purpose of monitoring daily weights, LPN #1 stated that the purpose was to monitor for fluid overload. When asked what check marks meant on the MARS/TARS, LPN #1 stated that checks marks meant a medication/treatment was administered. When asked where daily weights were documented, LPN #1 stated daily weights were documented in the clinical record; under the vital sign tab in PCC or in a nursing note. When asked if it was ever okay to document a weight was completed when it was not obtained, LPN #1 stated that it was never okay to document something was done

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when it was not. When asked why she documented a daily weight was completed for Resident #6 on 6/9/18 and 6/10/18 if a weight was not recorded in the clinical record, LPN #1 stated, "My CNAs get weights for me. I have to go." LPN #1 then hung up the phone.

On 6/22/18 at 12:02 p.m., ASM #1, the administrator, ASM #2, the DON (Director of Nursing), and ASM #4, the Regional Director of Operations, were made aware of the above concerns. No further information was presented prior to exit.

The facility policy titled, "Interdisciplinary Care Plan" does not address following the care plan.

According to Potter and Perry's, Fundamentals of Nursing, 7th Edition, page 269 states "A written care plan communicates nursing care priorities to other health care professionals. The nursing care plan enhances the continuity of care by listing specific nursing interventions needed to achieve the goals of care. The complete care plan is the blueprint for nursing action. It provides direction for implementation of the plan plus the framework for evaluation of the client's response to nursing actions."

4b. The facility staff failed to obtain weights for Resident #6, prior to dialysis per the physician's orders and the comprehensive care plan.

Review of Resident #6's POS (physician order summary) dated 6/1/18, documented the following orders: "Weight prior to dialysis on Monday, Wednesday, Friday." This order was initiated on 1/12/18. "Daily Weights- obtain and

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record- report gain of > (greater) than 3 pounds in 24 hours or < (less than) 5 lbs (pounds) in one week one time a day for heart failure." This order was initiated on 4/13/18.

Review of Resident #6's Renal Care Plan dated 3/19/18 documented the following intervention: "Obtain daily weights as ordered as well as prior to dialysis sessions."

Review of Resident #6's June 2018 MAR (medication administration record) revealed that Resident #6 has had dialysis on the following days:

6/1/18
6/4/18
6/6/18
6/8/18
6/11/18
6/13/18
6/15/18
6/18/18
6/20/18

On 6/1/18, it was documented that Resident #6 had refused his weight.

On 6/4/18, 6/6/18, and 6/18/18; a check mark was documented on the MAR indicating that these weights were obtained prior to dialysis. A weight for 6/4/18 could not be found in the clinical record. A weight for 6/4/18 could not be found on the paper weight log kept at the nursing station. The dialysis communication form for 6/4/18 could not be found in the dialysis book.

Review of the dialysis communication form dated 6/6/18 revealed that the weight documented for

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6/6/18 was not prior to dialysis. The weight was recorded from 6/5/18 at 11:20 a.m. The following was documented: "Weight: 126.2, date: 6/5/18 at 11:20 a.m."

Review of the dialysis communication form dated 6/18/18 revealed that the weight documented for 6/18/18 was not prior to dialysis. The weight recorded was from 6/7/18 at 1:39 p.m. The following was documented: "Weight 128.6, date 6/7/18 at 139 p.m."

Further review of the June MAR revealed that the resident was documented as being "Absent from home" on the following dialysis days: "6/8/18, 6/11/18, and 6/15/18."

Weights for 6/8/18, 6/11/18, and 6/15/18 could not be found in the clinical record. Further review of the clinical record revealed that Resident #6 was coded as being "Absent from home" because he was at dialysis. Review of the dialysis communication form dated 6/8/18, 6/11/18 and 6/15/18, revealed blanks indicating that the weights were not obtained prior to dialysis.

Further review of the June 2018 MAR revealed a blank or hole for the dialysis day 6/13/18. A weight could not be found in the clinical record. A weight could not be found on the weight log kept at the nursing station. Review of dialysis communication form dated 6/13/18 revealed a blank for weight, indicating that the weight was not obtained prior to dialysis.

Review of the June 2018 MAR revealed the following documented for 6/20/18: "Hold/See Nurse/Note." Review of the nursing notes failed

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to evidence why his weight was not obtained prior to dialysis.

On 6/21/18 at 12:00 p.m., an interview was conducted with Resident #6. Resident #6 stated that the facility staff checked his weight about 50 percent of the time.

On 6/21/18 at 12:31 p.m., an interview was conducted with LPN (licensed practical nurse) #2, Resident #6's nurse that shift. When asked what the following order meant: "Weight prior to dialysis on Monday, Wednesday, Friday," LPN #2 stated that weights should be obtained prior to dialysis. When asked if that meant right before the resident leave for dialysis, LPN #2 stated yes, it meant for that day before the resident leaves for dialysis. LPN #2 stated the 11-7 shift completed the dialysis forms in the book but weights were obtained by the day shift. LPN #2 stated that Resident #6 leaves early in the morning for dialysis. LPN #2 stated it appeared nursing was documenting the weight in the dialysis books using a weight from the day before. When LPN #2 was shown the weight recorded for 6/18/18, (dialysis day) was from 6/7/18; LPN #2 stated it appeared daily weights were also not being completed. When asked if this was following the physician's order and comprehensive care plan, LPN #2 stated, it was not. LPN #2 could not determine why some weights were missing from the dialysis book, the vital signs section under PCC and the weight logbook. LPN #2 stated the weight may have been done but not charted. LPN #2 confirmed she had filled out the dialysis communication form on 6/20/18. When asked why she used the weight from 6/19/18 at 3:46 p.m., LPN #6 stated she guessed the order should be clarified because she wasn't sure if the

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weight had to be right before dialysis or just the most recent weight has to be documented. LPN #2 could not recall why she documented "Hold/See nurses note" on the June MAR for 6/20/18. LPN #2 stated she has only worked with Resident #6 for a few days. LPN #2 stated that she was new at the facility.

On 6/22/18 at 8:20 a.m., an interview was conducted with CNA (certified nursing assistant) #1. When asked who was responsible for weighing residents, CNA #1 stated that two aides and one nurse will weight a resident together and the nurse will record the weight. When asked what the following order meant: "Weight prior to dialysis on Monday, Wednesday, Friday," CNA #1 stated a weight should be obtained before the resident leaves for dialysis. CNA #1 stated she did not work with Resident #6, and did not currently have any dialysis patients with that kind of order.

On 6/22/18 at 8:25 a.m., further interview was conducted with LPN #2. When asked what the checks meant on the MAR under a medication and treatment, LPN #2 stated that checks meant a medication was administered or a treatment was provided. When asked if it was ever okay to sign off that a treatment/medication was given when it in fact was not, LPN #2 stated that it was not okay. When asked why nurses were documenting that weights were being completed when they were not, LPN #2 stated she wasn't sure why because she thought a window popped up for the weight to be entered in PCC. LPN #2 stated that she heard that Resident #6 refused weights. When asked about the process followed if a resident refuses weights, LPN #2 stated that the MD (medical doctor) and family has to be

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notified and a nursing note has to be documented. When asked about the process followed if a resident consistently refuses weights, LPN #2 stated that it should be updated on the care plan. LPN #2 stated that it was not on his care plan that he refused weights.

On 6/22/18 at 12:02 p.m., ASM #1, the administrator, ASM #2, the DON (Director of Nursing), and ASM #4, the Regional Director of Operations, were made aware of the above concerns.

5. The facility staff failed to ensure a fall mat was in place per the comprehensive plan of care for Resident #50.

Resident #50 was admitted to the facility on 1/6/14 and readmitted on 4/13/18 with diagnoses that included but were not limited to type two diabetes, atrial fibrillation, heart failure, and high blood pressure. Resident #50's most recent MDS (minimum data set) assessment was an annual assessment with an ARD (assessment reference date) of 5/7/18. Resident #50 was coded as being cognitively intact in the ability to make daily decisions, scoring 12 out of 15 on the BIMS (Brief Interview for Mental Status) Exam. Resident #50 was coded as requiring extensive assistance with one staff member for bed mobility, toileting, and personal hygiene; and extensive assistance from two plus staff members for transfers.

Review of Resident #50's clinical record revealed that she had a fall on 3/9/18. The following was documented: "Found on floor next to bed on R (right) side at 4:05 p.m. No neuro (neurological)

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changes noted. Pulse is 124 RR (respirations) is 24 BP (blood pressure) is 134/92. Unable to extend R (right) leg in bed, c/o (complained) pain in hip area. Physician notified and order received to send guest out at 4:10 p.m. Daughter (Name of daughter), notified and requests (Name of hospital). Transported at this time to (Name of hospital) via (Name of EMT [emergency medical transport] Service). "

A fall assessment was completed on 3/6/18 (three days) prior to the fall documenting Resident #50 as being a low risk for falls.

Further review of the clinical record revealed that Resident #50 arrived back to the facility on 3/13/18 with a diagnosis of a right hip fracture.

Review of Resident #50's fall care plan revealed the following intervention was initiated on 3/14/18 on her comprehensive care plan: "Mat to floor next to bed."

Review of Resident #50's admission comprehensive assessment dated 3/13/18, documented Resident #50 as being a low risk for falls. The following Fall intervention was documented as needing to be in place: "Fall Care Plan: Mat to floor next to bed."

On 6/19/18 through 6/22/18 the following observations were made:

6/19/18 at 6:42 p.m., Resident #50 was lying in bed with her bed up against the right side of wall. There was no fall mat in place to the left side.

6/20/18 at 2:55 p.m., Resident #50 was lying in bed with her bed up against the right side of wall.

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There was no fall mat in place to the left side.

6/21/18 at 5:00 p.m., Resident #50 was lying in bed with her bed up against the right side of wall. There was no fall mat in place to the left side.

On 5/21/18 at 5:09 p.m., an interview was conducted with CNA (Certified nursing assistant) 2, Resident #50's CNA. When asked how CNAs know what interventions need to be in place for their residents to prevent falls, CNA #2 stated that the CNAs receive verbal report from the nurses. CNA #2 also stated that they could look at their care kardex, which serve as a guide for the aides to follow. When asked if Resident #50 was a fall risk, CNA #2 stated that Resident #50 does not try to get out of bed or her chair unassisted. When asked if Resident #50 needed a fall mat down beside her bed, CNA #2 stated, "No. She hasn't had a fall mat since I've been here." When asked how long CNA #2 had been working at the facility, CNA #2 stated, "A year."

Review of Resident #50 most recent care kardex, did not reveal the intervention for the fall mat.

On 6/21/18 at 5:05 p.m., an interview was conducted with LPN (licensed practical nurse) #3, Resident #50's nurse. When asked if Resident #50 was a fall risk, LPN #3 stated that after her fall on 3/9/18, she thought the resident was at least a low fall risk. When asked if Resident #50 is supposed to have a fall mat in place, LPN #3 stated she didn't think so. When asked how it is communicated to CNAs residents' needs such as fall prevention interventions, LPN #3 stated nurses verbally communicate with them and give them an update on resident care and the aides also had a care card. When asked the purpose of

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the comprehensive care plan, LPN #3 stated the purpose was to identify limitations, needs, goals, and serve as a guide for resident care. LPN#3 stated the care plan should be followed unless the care plan was out of date. LPN #3 stated it was important for the care plan to be accurate.

On 6/22/18 at 9:22 a.m., further interview was conducted with LPN#3. LPN #3 confirmed Resident #50's fall mat was on the care plan. LPN #3 stated Resident #50 does not attempt to get out of bed, and the care plan should probably be updated.

On 6/22/18 at 11:19 a.m., an interview was conducted with ASM (administrative staff member) #2, the DON (Director of Nursing). ASM #2 stated she thought the fall mat intervention was an error on the comprehensive care plan because it was not an intervention of the baseline care plan. When asked if the care plan was ever updated, ASM #2 stated that care plans were updated with any changes in condition, on admission and quarterly.

On 6/22/18 at 12:02 p.m., ASM #1, the administrator, ASM #2, the DON (Director of Nursing), and ASM #4, the Regional Director of Operations, were made aware of the above concerns. No further information was presented prior to exit.

6. The facility staff failed to follow the comprehensive care plan for obtaining physician ordered daily weights for Resident #74.

Resident #74 was admitted to the facility on 5/24/18 with the diagnoses of but not limited to congestive heart failure, chronic obstructive pulmonary disease, atrial fibrillation, diabetes, left

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heel pressure ulcer, glaucoma, high blood pressure, chronic kidney disease, and a heart attack. The most recent MDS (Minimum Data Set) was an admission assessment with an ARD (Assessment Reference Date) of 5/31/18. The resident was coded as cognitively intact in ability to make daily life decisions.

A review of the clinical record revealed an order dated 5/26/18 for "Daily weights in the morning for LVAD (Left ventricular assist device) management. NOTIFY PHYSICIAN IF WEIGHT GAIN OF 2 or MORE LBS (pounds) IN 24 HOURS OR 4 OR MORE LBS OVER 5 DAYS."

A review of the care plan revealed one dated 6/3/18 for "Cardiac: At risk for decreased Cardiac Output r/t (related to), HTN (high blood pressure), HLD (hyperlipidemia), A-Fib (atrial fibrillation), CAD (coronary artery disease), CHF (congestive heart failure), Pacemaker...." A review of the interventions included one dated 6/3/18 for "Obtain weight and track changes, report to the physician as needed."

A review of the MAR (Medication Administration Record) revealed that there were no weights obtained on 6/8/18, 6/11/18, 6/17/18, and 6/19/18.

In addition, further review of the MAR revealed the following:

- On 6/1/18 the resident weighed 184.6. On 6/2/18, the resident weighed 186.6. This was a 2-pound weight gain in 24 hours.

- On 6/7/18, the resident weighed 185.2. There was no weight obtained on 6/8/18. On 6/9/18, the resident weighed 192.6. This was a 7.4-pound

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weight gain in 2 days. There was no evidence the resident refused to have the weight obtained on 6/8/18.

- On 6/14/18, the resident weighed 189.8. On 6/15/18, the resident weighed 193. This was a 3.2-pound weight gain in 1 day.

- On 6/17/18 and 6/19/18 there were no weights obtained. However, subsequent weight the following day for each date showed a weight loss from the previous weight. There was no evidence the resident refused to have the weight obtained on 6/17/18 and 6/19/18.

On 6/21/18 at 11:12, in an interview with RN #4 (Registered Nurse), when asked what staff do with an order like the one documented above, RN #4 stated the weights should be obtained and if weights are not on the MAR it most likely was not done. When asked the importance of following this order, RN #4 stated that if the resident has CHF she is retaining fluid and potentially could have a lot of issues.

On 6/22/18 at 1:44 p.m., in an interview with LPN #6 (Licensed Practical Nurse), LPN #6 stated if the care plan documents to obtain the weights and the weight was not obtained, then the care plan was not followed.

A review of the facility policy, "Interdisciplinary Care Plan" failed to document any direction for ensuring the care plan is followed.

On 6/22/18 at 12:30 p.m., ASM #1 (Administrative Staff Member, the Administrator) and ASM #2 (the Director of Nursing) were made aware of the findings.

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No further information was provided by the end of the survey.

7. The facility staff failed to follow the comprehensive care plan to obtain daily weights for Resident #311.

Resident #311 was admitted to the facility on 6/8/18 with diagnoses that included but were not limited to: infection of the hip, heart failure, irregular heart beat, diabetes, high blood pressure and urinary tract infection.

The most recent MDS (minimum data set) an admission assessment with an ARD (assessment reference date) of 6/15/18 coded the resident as having scored a 12 out of 15 on the brief interview for mental status, indicating the resident was moderately impaired to make daily decisions.

Review of the resident's care plan initiated on 6/21/18, documented, "Focus. CARDIAC: At risk for decreased Cardiac Output R/T (related to): HTN (hypertension), A-Fib (atrial fibrillation -- an irregular heartbeat), and CHF (congestive heart failure). Interventions. Obtain weight and track changes. Administer medications as ordered."

Review of the June 2018 physician's orders documented, "daily weight in the morning for chf (congestive heart failure). Start Date: 6/12/18."

Review of the June 2018 TAR (treatment administration record) documented, "daily weight in the morning for chf." Review of the TAR failed to evidence documentation of the resident's weight on 6/12, 6/13, 6/14, 6/15, 6/19 or 6/20/18.

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Review of the vital signs and weight summary record did not evidence documentation of the resident's weight for the above dates.

Review of the nurse's notes for the dates above did not evidence documentation regarding the resident's weight.

An interview was conducted on 6/21/18 at 11:57 a.m. with RN (registered nurse) #1, the unit manager. When asked to review Resident #311's record for the daily weights, RN #1 stated, "Maybe they're in the weight book." RN #1 got the weight book and turned to the resident's name, there was no documentation of weights on the dates documented above. When asked why residents had care plans, RN #1 stated, "Why do they have care plans? So we know how to care for the patient." When asked who used the care plan, RN #1 stated, "The IDT (interdisciplinary team)." When asked if staff were expected to follow the care plan, RN #1 stated, "Yes."
.
An interview was conducted on 6/21/18 at 12:40 p.m. with LPN (licensed practical nurse) #8. When asked if there was, any reason a care plan would not be followed, LPN #8 stated, "No. Only if it's endangering the resident."

On 6/22/18 at 12:10 p.m. ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing were made aware of the findings.

No further information was provided prior to exit.

According to Fundamentals of Nursing Lippincott Williams and Wilkins 2007 pages 65-77 documented, "A written care plan serves as a

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communication tool among health care team members that helps ensure continuity of care...The nursing care plan is a vital source of information about the patient's problems, needs, and goals. It contains detailed instructions for achieving the goals established for the patient and is used to direct care...expect to review, revise and update the care plan regularly, when there are changes in condition, treatments, and with new orders..." (1)

(1) Fundamentals of Nursing Lippincott Williams & Wilkins 2007 Lippincott Company Philadelphia pages 65-77.

Basic Nursing, Essentials for Practice, 6th edition, (Potter and Perry, 2007, pages 119-127), was a reference for care plans. "A nursing care plan is a written guideline for coordinating nursing care, promoting continuity of care and listing outcome criteria to be used in the evaluation of nursing care. The written care plan communicates nursing care priorities to other health care professionals. The care plan also identifies and coordinates resources used to deliver nursing care. A correctly formulated care plan makes it easy to continue care from one nurse to another. If the patient's status has changed and the nursing diagnosis and related interventions are no longer appropriate, modify the nursing care plan. An out of date or incorrect care plan compromises the quality of nursing care."

8. The facility staff failed to follow the comprehensive care plan to administer medications as ordered for diabetes for Resident #108.

Resident #108 was admitted to the facility on

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6/7/18 with diagnoses that included but were not limited to: diabetes, depression, high cholesterol, high blood pressure and heart disease.

The most recent MDS (minimum data set) a five day assessment with an ARD (assessment reference date) of 6/14/18 coded the resident as scoring a 15 out of 15 on the brief interview for mental status. Resident #108 was coded as requiring staff assistance for activities of daily living except for eating which the resident could perform independently.

A medication administration observation was made on 6/20/18 at 8:58 a.m. with LPN (licensed practical nurse) #7. LPN #7 took two Humalog insulin pens from the medication cart and set the dose to five units on one pen and eight units on the other pen. LPN #7 then went into Resident #108's room at approximately 9:03 a.m. and administered the insulin in the resident's right and left abdomen. The resident stated he had eaten breakfast around 8:30 a.m.

Review of the care plan initiated on 6/13/18 documented, "Focus: At risk for fluctuation (sic) blood sugars R/T (related to): Diabetes. Interventions. Administer medication per order."

Review of the June 2018 physician's orders documented, "HumaLOG (1) kwikPen Solution 100 UNIT/ML (milliliter) Inject 5 unit subcutaneously before meals for diabetes. HumaLOG KwikPen Solution 100 unit/ML inject as per sliding scale: if 141 - 180 = 2u (units); 181 - 220 = 4u; 221 - 260 = 6u; 261 - 300 = 8u; 301 - 350 =10u; 351 - 400 = 14u; 401 - 402 = 14u call md (medical doctor) subcutaneously (below the skin) before meals and at bedtime for dm

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(diabetes mellitus)."

Review of the June 2018 MAR (medication administration record) documented the above physician's orders. The medication was documented as scheduled for administration to the resident at 7:30 a.m., 11:30 a.m., 5:30 p.m. and 8:00 p.m.

An interview was conducted on 6/21/18 at 12:18 p.m. with LPN #7 and RN (registered nurse) #1, the unit manager. When asked what time frame a medication could be given, LPN #7 stated, "We have some leeway. We're expected to give it right away." When asked when Resident #108's morning insulin was to be given, LPN #7 stated, I think it was 7:30 (a.m.)." When asked if she recalled what time she gave the insulin to Resident #108 on 6/20/18, LPN #7 didn't have a response. When informed the medication had been given a few minutes after nine, LPN #7 did not have a response. When asked if there was any consequence to giving insulin one and a half hours late and after breakfast, LPN #7 stated, "I'm not sure." RN #1 stated, "They can give medication an hour before and an hour after the ordered time." When asked if LPN #7 had administered the insulin within the correct timeframe, RN #1 stated she had not.

On 6/22/18 at 12:10 p.m. ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing were made aware of the findings.

No further information was provided prior to exit.

9. The facility staff failed to follow Resident #23's comprehensive care plan for fluid restrictions.

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Resident #23 was admitted to the facility on 2/28/18, with diagnoses that included but were not limited to: heart disease, high blood pressure, hyponatremia (Low sodium level in the blood) (1), bipolar disorder (a mental illness which includes unusual mood changes) (2), and muscle weakness.

The most recent MDS (minimum data set) assessment, a quarterly assessment, with an ARD (assessment reference date) of 4/4/18, coded the resident as scoring a 15 on the BIMS (brief interview for mental status) score, indicating that she had no cognitive impairment.

A review of the comprehensive care plan dated 3/5/18, with a most recent revision on 3/12/18, documented in part, "Need: At nutritional risk and/or dehydration R/T (related to): decreased appetite ...hyponatremia, diuretic use and fluid restriction". In the Interventions section of this need was documented in part, "Follow fluid restrictions as ordered".

A physician's order with a start date 3/6/18 documented an order of "1200 cc QD (every day) every 24 hours 1200cc fluid restriction". This order does not have a discontinuation date.

A review of Resident #23's fluid intake report documented that Resident #23 exceeded the ordered fluid amount on 6/2/18 with a fluid intake of 1600 cc, on 6/4/18 with a fluid intake of 1400 cc, and on 6/14/18 with a fluid intake of 1540 cc.

On 6/21/18 at 3:28 p.m., LPN (licensed practical nurse) #8, was asked why residents have care plans. LPN #8 stated to improve care and for the

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 111 staff and resident to work towards the common goal of discharge. When asked who uses the care plans, she stated, "Anybody who has anything to do with the person's care should have access to review the care plan". She further noted that "Care plans need to be accurate to ensure the best quality of care". On 6/21/18 at approximately 4:15 a.m., RN (registered nurse) #1 was asked how it could be confirmed that the care plan is being followed. RN #1 stated, "If the nursing notes do not reflect any interventions by the staff when the fluid restriction is exceeded, then the staff is not following the care plan". ASM #1 (the administrator), ASM #2, (the director of nursing), ASM #4, (the regional director of operations), and ASM #5 (the regional clinical coordinator) were made aware of the above concern on 6/22/18 at 12:02 p.m. No further information was provided prior to exit. (1) This information was obtained from the following website: https://medlineplus.gov/ency/article/000394.htm (2) This information was obtained from the following website: https://medlineplus.gov/bipolardisorder.html	F 656		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment.	F 657		8/3/18

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F 657	Continued From page 112 (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, facility document review and clinical record review, it was determined the facility staff failed to review and revise the comprehensive care plan for one of 32 residents in the survey sample, Resident #23. The facility staff failed to review or revise Resident #23's comprehensive care plan to reflect her noncompliance with physician ordered fluid restrictions. The findings include: Resident #23 was admitted to the facility on	F 657	Resident #23 care plan has been revised to reflect resident's non-compliance with ordered fluid restrictions. All residents with fluid restrictions have the potential to be affected. MDS Nurses will be educated by DON/Designee regarding updating comprehensive care plans for fluid restriction non- compliance. DON/Designee during morning clinical meeting to conduct quality monitoring of resident non-compliance of fluid restrictions, 5x week x1 week, then	

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F 657	Continued From page 113 2/28/18, with diagnoses that included but were not limited to: heart disease, high blood pressure, hyponatremia (Low sodium level in the blood) (1), bipolar disorder (a mental illness which includes unusual mood changes) (2), and muscle weakness. The most recent MDS (minimum data set) assessment, a quarterly assessment, with an ARD (assessment reference date) of 4/4/18, coded the resident as scoring a 15 on the BIMS (brief interview for mental status) score, indicating that she had no cognitive impairment. She was coded as always understanding others and always making herself understood. Resident #23 was coded as requiring extensive assistance of one or more staff members for bed mobility, transfers, toileting, and personal hygiene. A review of the comprehensive care plan dated 3/5/18, with a most recent revision on 3/12/18, documented in part, "Need: At nutritional risk and/or dehydration R/T (related to): decreased appetite ...hyponatremia, diuretic use and fluid restriction". In the Interventions section of this need it is documented in part, "Follow fluid restrictions as ordered". A physician's order with a start date 3/6/18 documented an order of 1200 cc QD (every day) every 24 hours 1200cc fluid restriction. This order does not have a discontinuation date. A review of Resident #23's fluid intake report documented that Resident #23 exceeded the ordered fluid amount on 6/2/18 with a fluid intake of 1600 cc, on 6/4/18 with a fluid intake of 1400 cc, and on 6/14/18 with a fluid intake of 1540 cc.	F 657	weekly x4 weeks and then monthly, PRN and as indicated. Findings to be communicated to the QA committee monthly and as indicated. Quality monitoring schedules modified based on findings.	

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On 6/20/18 at 08:58 a.m., an interview was conducted with Resident #23. When asked if she was aware of a physician's order restricting her fluid intake she stated "Yes." When asked about the numerous unopened soda cans on her bedside table, Resident #23 stated, "They told me I could drink as many of those as I wanted because they [the sodas] don't count." When asked who told her this, Resident #23 responded "The staff." When asked if the staff had explained to her why she needed to count the sodas in her daily fluid intake, Resident #23 stated, "No...

An interview was conducted on 6/21/18 at 2:20 p.m. with CNA (certified nursing assistant) #4. CNA #4 was asked exactly what fluids are recorded on the daily intake report. She stated the fluids from the resident's food trays and any amount the nurses give the resident with medications. When asked if she communicated the daily fluid intakes to the nurses CNA #4 stated, "Yes, we tell the nurses the amount, then they tell us the amount from medications, and it is added together into the report." CNA #4 was shown the June intake report for Resident #23 and was asked about the days where the fluid restriction was exceeded. CNA #4 stated, "The resident sneaks sodas". When asked if this was communicated to the nurses, CNA #4 stated "Yes."

On 6/21/18 at 2:25 p.m., an interview was conducted with LPN (licensed practical nurse) #7. LPN #7 confirmed that the nursing staff communicate with each other and that she lets the CNAs know how much fluid the resident receives when taking their medication. When asked what nursing does when the resident has

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exceeded the daily fluid limit, LPN #7 stated they document it. LPN #7 further stated, "[Resident #23's name] has been noncompliant with her fluid restriction many times." When asked if Resident #23's noncompliance was documented in the nursing notes or in the comprehensive care plan, LPN #7 stated she did not know.

A review of the nurse's notes from 6/1/18 to 6/20/18 failed to document any education or interventions were provided to Resident #23 regarding her noncompliance with the physician ordered fluid restriction.

On 6/21/18 at 3:28 p.m., LPN (licensed practical nurse) #8 was asked why residents have care plans. She stated to improve care and for the staff and resident to work towards the common goal of discharge. When asked who uses the care plans, she stated, "Anybody who has anything to do with the person's care should have access to review the care plan." LPN #8 further noted that "Care plans need to be accurate to ensure the best quality of care." When asked why a care plan might be revised, LPN #8 stated, "If the resident has a change in condition."

On 6/21/18 at 4:15 a.m., RN (registered nurse) #1, she stated, "If the nursing notes do not reflect any interventions by the staff when the fluid restriction is exceeded or the resident's noncompliance, then the staff is not following the care plan."

On 6/22/18 at 10:55 a.m., ASM (administrative staff member), the director of nursing, #2 was asked when a care plan should be revised. ASM #2 stated, "When a resident has a change in condition or a new behavior is noted." When

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F 657	Continued From page 116 asked why a care plan is revised, ASM #2 stated "Lots of things, like falls. There are a lot of reasons to update a care plan." When asked if a residents noncompliance would be care planned, ASM #2 stated, "Yes, noncompliance should care planned as it is person centered and should include education about consequences of not following M.D.'s (medical doctor's) orders." ASM #1 (the administrator), ASM #2, (the director of nursing), ASM #4, (the regional director of operations), and ASM #5 (the regional clinical coordinator) were made aware of the above concern on 6/22/18 at 12:02 p.m. No further information was provided prior to exit. (1) This information was obtained from the following website: https://medlineplus.gov/ency/article/000394.htm (2) This information was obtained from the following website: https://medlineplus.gov/bipolardisorder.html	F 657		
F 658 SS=E	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, facility document review and clinical record review, it was determined that the facility staff failed to follow professional standards of practice for nine of 32 residents in the survey	F 658	Resident #311s order for intravenous dressing has been clarified. Resident #308 no longer resides in this facility. Resident #108s narcotic pain medication has been updated to include parameters	8/3/18

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F 658	Continued From page 117 sample, Resident #311, 308, 108, 50, 6, 74, 67, 1 and 105. 1. The facility staff failed to clarify a physician's order to change the intravenous dressing for Resident #311. 2. The facility staff failed to document the blood sugar on four occasions in June 2018 for Resident #308. 3 a. The facility staff failed to clarify the parameters for as needed narcotic pain medication administration for Resident #108. 3 b. The facility staff failed to clarify the location of the topical pain medication was to be administered for Resident #108. 4. The facility staff failed to evidence that an intervention was implemented when Resident #50's blood sugar reading was at a level of 50 on 4/6/18. 5 a. The facility staff were documenting that Resident #6's weights were completed prior to dialysis when then were not obtained prior to dialysis. 5 b. The facility staff were documenting that Resident #6's daily weights were completed on the June 2018 MAR, when they were not obtained daily. 5 c. The facility staff failed to clarify three as needed physician orders for pain medication for Resident #6. 6. The facility staff failed to follow professional	F 658	and location of resident's pain. Resident #50s blood sugars are being monitored and addressed as per MD order. Resident #6s weights are being obtained and documented as per Physician order. Resident #6s pain medication has been clarified. Resident #74 no longer resides in this facility. Resident #67 no longer resides in this facility. Resident #1s no longer resides in this facility. Resident #105 no longer resides in this facility. All residents have the potential to be affected. The DON/designee to educate nursing staff on ensuring orders are in place for intravenous dressing changes, weights are being obtained/documented and weight gain are reported to the Physician as per Physician order, blood sugars are being monitored, documented and interventions are being followed as per Physician orders and pain medications are ordered with parameters. DON/designee during morning clinical meeting to conduct quality monitoring 5x week x1 weeks, weekly x4 and then monthly, PRN and indicated.	

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standards for documenting physician notification of the physician of Resident #74's weight gain of 2 or more pounds in 24 hours or 4 or more pounds in 5 days per physician's order.

7. The facility staff failed to clarify the physician's order for Resident #67 for the administration of Lidocaine {1} gel 2% to labia.

8. The facility staff failed to clarify the physician's orders for as needed Dilaudid (3) pain medication for Resident #1.

9. The facility staff failed to clarify the physician's orders for as needed pain medication for Resident #105.

The findings include:

1. Resident #311 was admitted to the facility on 6/8/18 with diagnoses that included but were not limited to: infection of the hip, heart failure, irregular heart beat, diabetes, high blood pressure and urinary tract infection.

The most recent MDS (minimum data set) an admission assessment with an ARD (assessment reference date) of 6/15/18 coded the resident as having scored a 12 out of 15 on the brief interview for mental status, indicating the resident was moderately impaired to make daily decisions.

An observation was made on 6/19/18 at 6:30 p.m. of Resident #311. The resident was awake and alert and sitting up on the side of the bed. The resident's wife was also in the room. The resident had a PICC (a peripherally inserted central

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catheter (1)) line in his right upper arm, which was covered with a transparent dressing. No date could be seen on the dressing. When asked if the dressing had been changed since he was admitted to the facility, Resident #311 and his wife both said it had not.

Review of the resident's baseline care plan initiated on 6/8/18 documented, "Infection Alert. PICC Line dressing (change) per order."

Review of the June 2018 physician's orders documented, "PICC line dressing change." There was no frequency documented.

Review of the June 2018 MAR (medication administration record) did not evidence a schedule for the PICC line dressing change. In the upper left corner of the MAR was a box labeled Unscheduled "Other" Orders. "PICC line dressing change" was documented in the box.

An interview was conducted on 6/21/18 at 11:35 a.m. with LPN (licensed practical nurse) #2. When asked about the process staff follows when a resident had a PICC line, LPN #2 stated, "So I clean the IV port with alcohol, take my saline syringe, and check for blood flow". When asked when the PICC line dressing was changed, LPN #2 stated, "Our protocol here is every seven days. First I'm going to check his orders." LPN #2 reviewed the resident's order and stated, "It looks like the order was put in on the eighth (6/8/18). It says 'PICC line dressing change' so it's not telling me how often to change it." LPN #2 then reviewed the June 2018 MAR and TAR (treatment administration record). LPN #2 stated, "There's nothing there. If the MD (medical doctor) wrote change PICC line dressing, I would clarify

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the orders to see how often he wants it; some of the doctors want it done every five days or some every seven days." When asked if the resident's PICC line dressing had been changed since admission, LPN #2 stated she did not think it had since there was no schedule and no place to document it.

An interview was conducted on 6/21/18 at 12:40 p.m. with LPN (licensed practical nurse) #8, a nurse who cared for the resident. When asked about the process staff follows when a resident had a PICC line, LPN #8 stated, "When you get them you make sure it's patent (functional). I think the dressing gets changed once a week or as needed." When asked why the dressing was changed, LPN #8 stated, "To avoid infection." When asked if she had changed Resident #311's PICC line dressing since admission, LPN #8 stated, "No."

On 6/22/18 at 12:10 p.m. ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing were made aware of the findings. ASM #2 was asked what professional standards the facility used, ASM #2 stated, "Lippincott and our policies." A request was made to ASM #2 at that time for a policy on clarifying physician's orders.

According to "Lippincott Manual Of Nursing Practice", Eighth Edition: by Lippincott Williams & Wilkins, pg. 15, the following is documented in part, "Inappropriate Orders: 2. Although you cannot automatically follow an order you think is unsafe, you cannot just ignore a medical order, either. b. .. Call the attending physician, discuss your concerns with him, obtain appropriate..orders. c. Notify all involved medical

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and nursing personnel.... d. Document clearly."

On 6/22/18 at 2:35 p.m. ASM #5, the director of nursing from an affiliated facility stated, "We don't have a policy on clarifying physician's orders."

Review of the facility's policy titled, "Central Venous Catheter (CVC) Dressing Change" did not evidence documentation regarding clarifying the physician's order.

No further information was provided prior to exit.

1. PICC -- A device used to draw blood and give treatments, including intravenous fluids, drugs, or blood transfusions. A thin, flexible tube is inserted into a vein in the upper arm and guided (threaded) into a large vein above the right side of the heart called the superior vena cava. A needle is inserted into a port outside the body to draw blood or give fluids. A PICC may stay in place for weeks or months and helps avoid the need for repeated needle sticks. Also called peripherally inserted central catheter. This information was obtained from: https://www.cancer.gov/publications/dictionaries/cancer-terms/def/picc

2. The facility staff failed to document the blood sugar on four occasions in June 2018 for Resident 308.

Resident #308 was admitted to the facility on 6/6/18 with diagnoses that included but were not limited to: irregular heart beat, diabetes, heart failure, high blood pressure and obesity.

The most recent MDS (minimum data set), an admission assessment, with an ARD

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(assessment reference date) of 7/13/18 coded the resident as having scored a 14 out of 15 on the brief interview for mental status indicating the resident was cognitively intact to make daily decisions.

Review of Resident #308's care plan initiated on 6/13/18 documented, "Need. At risk for fluctuation (sic) blood sugars R/T (related to): Diabetes. Interventions. Administer medications per orders. "

Review of the June 2018 physician's orders documented, "CHECK BLOOD SUGAR AC (before meals) and HS (bedtime) before meals and at bedtime for DM2 (diabetes mellitus type 2 [1])."

Review of the June 2018 MAR documented, "CHECK BLOOD SUGAR AC (before meals) and HS (bedtime) before meals and at bedtime for DM2." Review of the MAR did not evidence documentation of the resident's blood sugar on 6/11/18 at 6:30 a.m. 6/12/18 at 6:30 a.m., 6/13/18 at 11:30 a.m. and 6/19/18 at 6:30 a.m.

Review of the resident's weights and vitals summary form did not evidence documentation of the blood sugar on the dates documented above.

Review of nurse's notes for Resident #308, did not evidence documentation of the blood sugars on the dates documented above.

An interview was conducted on 6/22/18 at 2:01 p.m. with LPN (licensed practical nurse) #3 and LPN #2. When asked what blank spaces on the MAR meant, LPN #3 stated, "Looking at it, it looks like it was never done or they forgot to

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document it." When asked if it was important to document blood sugars, LPN #2 stated, "Because you want to know if the patient is stable. How would you know if you don't document it, you don't know if they're hypoglycemic (low blood sugar) or hyperglycemic (high blood sugar)."

On 6/22/18 at 12:10 p.m. ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing were made aware of the findings. ASM #2 was asked what professional standards the facility used, ASM #2 stated, "Lippincott and our policies."

According to "Lippincott Manual Of Nursing Practice", Eighth Edition : by Lippincott Williams & Wilkins, Chapter 25, Diabetes Mellitus, pg. 912, "Blood Glucose Monitoring" Accurate determination of capillary blood glucose assists patients in the control and daily management of diabetes mellitus. Blood glucose monitoring helps evaluate effectiveness of medication; reflects glucose ecursion after meals; assesses glucose response to exercise regimen; and assists in the evaluation of episodes of hypoglycemia and hyperglycemia to determine appropriate treatment."

No further information was provided prior to exit.

1. Diabetes mellitus type 2 -- Diabetes means your blood glucose, or blood sugar, levels are too high. With type 2 diabetes, the more common type, your body does not make or use insulin well. Insulin is a hormone that helps glucose get into your cells to give them energy. Without insulin, too much glucose stays in your blood. Over time, high blood glucose can lead to serious problems

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with your heart, eyes, kidneys, nerves, and gums and teeth. This information was obtained from: https://medlineplus.gov/diabetestype2.html (3) This information was obtained from the following website: https://medlineplus.gov/ency/article/003481.htm

3 a. The facility staff failed to clarify the parameters for as needed narcotic pain medication administration for Resident #108.

Resident #108 was admitted to the facility on 6/6/18 with diagnoses that included but were not limited to: fractured leg, bacterial infection, anemia, depression and high blood pressure.

There was not completed MDS (minimum data set) at the time of the survey. Review of the nurse's comprehensive evaluation dated 6/6/18 documented, that the resident was oriented to time, place and person. The resident was documented as needing assistance from staff for activities of daily living.

Review of the resident's care plan initiated on 6/7/18 documented, "Need. Potential for pain r/t (related to): impaired mobility.... Interventions. Administer medications for pain and observe for effectiveness effects and report ineffectiveness to physician."

Review of the June 2018 physician's orders documented, "Hydrocodone-Acetaminophen (1) Tablet 5-325 MG (milligrams) Give 1 tablet by mouth every 4 hours as needed for pain. Start Date: 6/6/18. Hydrocodone-Acetaminophen Tablet 5-325 MG Give 2 tablet (sic) by mouth every 4 hours as needed for pain. Start Date:

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6/7/18." The one tablet dose was documented as being administered on 6/7 on two occasions, 6/10, 6/12, 6/13, 6/16 and 6/17/18 on two occasions for pain ratings of 5, 3, 4, 7, 3, 4, 5, 5 respectively. The two tablet dose was documented as being administered on 6/7, 6/8 on three occasions, 6/9 on four occasions, 6/10 on three occasions, 6/11 on three occasions, 6/12 on two occasions, 6/13 on three occasions, 6/14 on two occasions and 6/15/18 on two occasions. The resident's pain level was documented as being, 5, 8, 8, 5, 5, 8, 8, 9, 7, 8, 5, 5, 4, 4, 4, 4, 4, 4, 3, 6, and 7 respectively.

An interview was conducted on 6/21/18 at 11:35 a.m. with LPN (licensed practical nurse) #2. When asked about the process staff follows when determining which pain medication to administer when the resident has two as needed pain medication dosages ordered, LPN #2 stated, "Asking him what is the pain level, I would leave it up to the resident as to which one they want to take." When asked to review Resident #109's orders for hydrocodone and the pain levels documented, LPN #2 didn't have an answer for why the medication was given as it was. When asked if it was in the nurse's scope of practice to determine at what pain level a medication would be given, LPN #2 didn't know.

An interview was conducted on 6/21/18 at 12:40 p.m. with LPN (licensed practical nurse) #8. When asked about the process staff follows when a resident has two as needed pain medication dosages ordered, LPN #8 stated, "Most of the time I rate their pain. I ask them if they want one or two pills. If I feel like they're alert enough I give them the option. If they're not alert and oriented I assess their cognitive level and what procedure

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was done. I look at what the other nurses have been giving."

On 6/22/18 at 12:10 p.m. ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing were made aware of the findings. ASM #2 was asked what professional standards the facility used, ASM #2 stated, "Lippincott and our policies."

Review of the facility's policy titled, "PAIN MANAGEMENT PROGRAM" documented, "Purpose: The Pain Management Program will provide the nursing staff with a structured approach for developing an appropriate care plan for pain management, and/or to evaluate the effectiveness of the current regimen." There was no documentation regarding clarifying pain medication parameters.

According to "Lippincott Manual Of Nursing Practice", Eighth Edition: by Lippincott Williams & Wilkins, pg. 87 read: "Nursing Alert: Unusual dosages or unfamiliar drugs should always be confirmed with the health care provider and pharmacist before administration." On pg. 15, the following is documented in part, "Inappropriate Orders: 2. Although you cannot automatically follow an order you think is unsafe, you cannot just ignore a medical order, either. b. .. Call the attending physician, discuss your concerns with him, obtain appropriate..orders. c. Notify all involved medical and nursing personnel.... d. Document clearly."

No further information was provided prior to exit.

1. Hydrocodone is a semisynthetic, moderately potent, orally available opioid that, in combination

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with acetaminophen, is widely used for treatment of acute or chronic pain, and in combination with antihistamines or anticholinergics used to treat cough. Hydrocodone by itself has not been linked to serum enzyme elevations during therapy or to clinically apparent liver injury, but the combination with acetaminophen has been linked to many cases of acute liver failure due to unintentional overdose with acetaminophen. This information was obtained from: https://livertox.nih.gov/Hydrocodone.htm

3 b. The facility staff failed to clarify the location of the topical pain medication was to be administered for Resident #108.

Review of the June 2018 physician's orders documented, "Voltaren (1) Gel 1% Apply 1 application transdermally four times a day for pain." There was no location documented for where the gel was to be applied.

Review of the June 2018 MAR (medication administration record) documented, "Voltaren (1) Gel 1% Apply 1 application transdermally four times a day for pain." There was no location documented for where the gel was to be applied. The medication was documented as being applied every day.

An interview was conducted on 6/21/18 at 11:35 a.m. with LPN (licensed practical nurse) #2. When asked what was included in a complete medication order, LPN #2 stated, "Right patient, right dose, right time, right medication and right route." When asked if staff needed to know where a topical pain medication should be applied, LPN #2 stated, "Yes." When asked to

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review Resident #109's order for Voltaren gel, LPN #2 stated, "Well it needs to be clarified so let's start right there." When asked why, LPN #2 stated, "It doesn't tell us where to put it."

An interview was conducted on 6/21/18 at 12:40 p.m. with LPN #8, the resident's nurse. When asked to review the resident's Voltaren gel order, LPN #8 stated, "It's missing something, I'd probably say the location." When asked if the location should be included in the order, LPN #8 stated yes. When asked if staff should have clarified the order with the physician, LPN #8 stated yes.

On 6/22/18 at 12:10 p.m. ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing were made aware of the findings.

According to "Lippincott Manual Of Nursing Practice", Eighth Edition : by Lippincott Williams & Wilkins, pg. 87 read: "Nursing Alert: Unusual dosages or unfamiliar drugs should always be confirmed with the health care provider and pharmacist before administration." on pg, 15, the following is documented in part, "Inappropriate Orders: 2. Although you cannot automatically follow an order you think is unsafe, you cannot just ignore a medical order, either. b. .. Call the attending physician, discuss your concerns with him, obtain appropriate..orders. c. Notify all involved medical and nursing personnel.... d. Document clearly."

No further information was obtained prior to exit.

1. Voltaren gel -- Voltaren® Gel is indicated for the relief of the pain of osteoarthritis of joints

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amenable to topical treatment, such as the knees and those of the hands. This information was obtained from: https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=b04009ca-7545-4cd4-af63-f15aebf20f18

4. The facility staff failed to evidence that an intervention was implemented when Resident #50's blood sugar reading was at a level of 50 on 4/6/18.

Resident #50 was admitted to the facility on 1/6/14 and readmitted on 4/13/18 with diagnoses that included but were not limited to type two diabetes, atrial fibrillation, heart failure, and high blood pressure. Resident #50's most recent MDS (minimum data set) assessment was an annual assessment with an ARD (assessment reference date) of 5/7/18. Resident #50 was coded as being cognitively intact in the ability to make daily decisions, scoring 12 out of 15 on the BIMS (Brief Interview for Mental Status) Exam. Resident #50 was coded as requiring extensive assistance with with one staff member for bed mobility, toileting, and personal hygiene; and extensive assistance from two plus staff members for transfers.

Review of Resident #50's April 2018 POS (physician order summary) revealed that she received Humalog (1) sliding scale insulin. The following order was documented:

"Humalog KwikPen Solution Pen-Injector 100 Unit/ML (milliliter) (insulin lispro) Inject per sliding scale:
If 141-180=4 units
181-220=6 units
221-260=8 units
261-300=10 units

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301-350 = 12 units
351-400 =16 units 401 or greater 16 units and call MD (medical doctor), subcutaneously before meals and at bedtime for DM (diabetes mellitus)."

Review of Resident #50's April 2018 MAR (medication administration record) revealed that on 4/6/18 at 11:30 a.m., her blood sugar was 50. There was no evidence that the physician was notified of this low blood sugar. There was no evidence that the nurse had put an intervention in place to increase her blood sugar.

Further review of Resident #50's meal intake report revealed that she had consumed 26-50 percent of her lunch that day.

Review of Resident #50's nursing notes revealed that on 4/6/18 at 4:37 p.m., Resident #50's blood sugar had risen to 80. At 4:45 p.m., Resident #50's blood sugar dropped down to 70 and then fifteen minutes later Resident #50 was unresponsive due to her blood sugar dropping to 32. There was evidence that the physician was notified at this time of Resident #50's unresponsiveness despite intervention to increase the blood sugar.

Review of Resident #50's diabetes care plan dated 3/14/18, documented the following: "Blood SU (sugar): At risk for fluctuation blood sugars R/T (related/to) Diabetes. Goal: Guest will be free from signs of complications from fluctuation blood sugars such as mental status changes...observe and document s/sx (symptoms) of complications from fluctuating blood sugar. Report abnormal findings to physician."

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On 6/21/18 at 1:18 p.m., an interview was conducted with LPN (licensed practical nurse) #4, the nurse who worked with Resident #50 on 4/6/18 at 11:30 a.m. When asked what she considered a low blood sugar, LPN #4 stated that it depended on the patient. When asked what she considered hypoglycemic (2), LPN #4 stated, "anything under 60." When asked the nursing process if a resident were to be hypoglycemic, LPN #4 stated that she would immediately give the resident juice to bring it up, recheck the blood sugar, monitor the resident closely, and then recheck the blood sugar again in thirty minutes. When asked if she would document these interventions, LPN #4 stated, "Yes." LPN #4 stated that she would document these interventions in a nursing note. When asked if she would notify the physician for a blood sugar reading of 50, LPN #4 stated, "I guess so. I would definitely make sure that the blood sugar had gone up." When asked about the protocol to use Glucagon (3), LPN #4 stated that she would use glucagon only if there was an order to use glucagon. LPN #4 stated that glucagon was not a standing order and she would have to call the physician to obtain an order. When asked if she was familiar with Resident #50, LPN #4 stated that she worked with Resident #50 on a number of occasions. When asked if she could recall Resident #50's blood sugar reading being 50 on 4/6/18 at 11:30 a.m., LPN #4 stated that she could not remember that far back. When asked if the initials on the MAR (medication administration record) were hers, LPN #4 stated, "Yes." When asked if the physician was notified regarding the low blood sugar reading of 50 at 11:30 a.m. on 4/6/18, LPN #4 stated that she was not sure and should have documented that information in a nursing note. LPN #4 could not determine either

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way if she had put an intervention in place. LPN #4 stated, "Maybe the 50 was a miscoding?" LPN #4 stated that if a blood sugar was that low she would stop and call the MD (medical doctor). When asked how this writer and other nurses would know what was done for Resident #50, LPN #4 stated, "You mean to tell me I recorded that her sugar was 50, and I didn't do anything?"

On 6/21/18 at 1:32 p.m., an interview was conducted with LPN #3. When asked what she considered hypoglycemic, LPN #3 stated, "Anything below 60." When asked the process if she were to have a resident with a blood sugar level of below 60, LPN #3 stated that she would provide the resident orange juice, graham crackers with peanut butter for protein, and she would check on them every 15 minutes. LPN #3 stated that if food interventions did not work, she would notify the MD to obtain an order for glucagon and administer. LPN #3 stated that she would still notify the MD for any hypoglycemic episode. LPN #3 stated, "It's something critical that happened to the resident." LPN #3 stated that she would always document interventions that were put into place and that the MD was made aware in a nursing note. When asked how nurses would know if interventions were put into place for a low blood sugar or that the physician was notified if there is no documentation in the clinical record, LPN #3 stated that the nurse may have put it on the 24 hour report. LPN #3 stated that if the nurse did not document on the 24-hour report than there was no way of knowing what was done.

The 24-hour report for 4/6/18 was requested from ASM (administrative staff member) #2, the DON (Director of Nursing).

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On 6/21/18 at approximately 2 p.m., the 24-hour report was presented for 4/6/18. The 7-3 shift box was completely blank.

On 6/21/18 at 1:56 p.m., an interview was conducted with ASM #3, the nurse practitioner. ASM #3 could not recall being made aware of Resident #50's low blood sugar. ASM #3 stated that she probably would have given an order to monitor and maybe administer glucagon. ASM #3 stated that a blood sugar reading under 70 was considered hypoglycemic. ASM #3 stated that she would first expect nursing to give juice, recheck in an hour and hold any ordered insulin. ASM #3 that she would expect nursing to make here aware of any hypoglycemic event. ASM #3 stated that nursing staff may have notified her but they just didn't document.

On 6/22/18 at 12:02 p.m., ASM #1, the administrator, ASM #2, the DON (Director of Nursing), and ASM #4, the Regional Director of Operations, were made aware of the above concerns. ASM #2 was asked what professional standards the facility used, ASM #2 stated, "Lippincott and our policies."

The facility policy titled, "Finger Stick Blood Sugar," documents in part, the following: "Finger stick blood sugars will be obtained by the licensed nurse or a qualified medication aide as directed by a physician's order or as a nursing measure for guests exhibiting signs and symptoms of hyper or hypoglycemia...Record blood sugar in the guest's Medication Administration Record (MAR), facility glucose tracking form, and/or the Progress Notes. Follow parameters designated by the physician's order and administer insulin

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coverage or notify the physician, as directed. If physician notification is necessary, document date and time of notification and the physician's response in the Progress notes.

(1) Humalog-Insulin lispro protamine and insulin lispro is a combination of a fast-acting insulin and an intermediate-acting type of human insulin. Insulin is used by people with diabetes to help keep blood sugar levels under control. This information was obtained from The National Institutes of Health. https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0010739/?report=details.

(2) Hypoglycemia means low blood glucose, or blood sugar. Your body needs glucose to have enough energy. After you eat, your blood absorbs glucose. If you eat more sugar than your body needs, your muscles, and liver store the extra. When your blood sugar begins to fall, a hormone tells your liver to release glucose. In most people, this raises blood sugar. If it doesn't, you have hypoglycemia, and your blood sugar can be dangerously low. Signs include Hunger, Shakiness, Dizziness, Confusion, Difficulty speaking, Feeling anxious or weak. In people with diabetes, hypoglycemia is often a side effect of diabetes medicines. Eating or drinking something with carbohydrates can help. This information was obtained from The National Institutes of Health. https://medlineplus.gov/hypoglycemia.html.

Hypoglycemia, also called low blood glucose or low blood sugar, occurs when the level of glucose in your blood drops below normal. For many people with diabetes, that means a level of 70 milligrams per deciliter (mg/dL) or less. This

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information was obtained from The National Institutes of Health. https://www.niddk.nih.gov/health-information/diabetes/overview/preventing-problems/low-blood-glucose-hypoglycemia.

(3) Glucagon injection is an emergency medicine used to treat severe hypoglycemia (low blood sugar) in diabetes patients. This information was obtained from The National Institutes of Health. https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0010481/?report=details.

5 a. The facility staff were documenting that Resident #6's weights were completed prior to dialysis when then were not obtained prior to dialysis.

Resident #6 was admitted to the facility on 12/6/17 with diagnoses that included but were not limited to end stage renal disease, heart failure, type two diabetes and COPD (chronic obstructive pulmonary disease). Resident #6's most recent MDS (minimum data set) assessment was a quarterly assessment with an ARD (assessment reference date) of 3/5/18. Resident #6's was coded as being cognitively intact in the ability to make daily decisions scoring 15 out of possible 15 on the BIMS (Brief Interview for Mental Status) exam.

Review of Resident #6's POS (physician order summary) dated 6/1/18, documented the following orders: "Weight prior to dialysis on Monday, Wednesday, Friday." This order was initiated on 1/12/18. "Daily Weights- obtain and record- report gain of > (greater) than 3 pounds in 24 hours or < (less than) 5 lbs (pounds) in one

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week one time a day for heart failure." This order was initiated on 4/13/18.

Review of Resident #6's Renal Care Plan dated 3/19/18 documented the following intervention: "Obtain daily weights as ordered as well as prior to dialysis sessions."

Review of Resident #6's June 2018 MAR (medication administration record) revealed that Resident #6 has had dialysis on the following days:

6/1/18
6/4/18
6/6/18
6/8/18
6/11/18
6/13/18
6/15/18
6/18/18
6/20/18

On 6/1/18, it was documented that Resident #6 had refused his weight.

On 6/4/18, 6/6/18, and 6/18/18; a check mark was documented on the MAR indicating that these weights were obtained prior to dialysis. A weight for 6/4/18 could not be found in the clinical record. A weight for 6/4/18 could not be found on the paper weight log kept at the nursing station. The dialysis communication form for 6/4/18 could not be found in the dialysis book.

Review of the dialysis communication form dated 6/6/18 revealed that the weight documented for 6/6/18 was not prior to dialysis. The weight was recorded from 6/5/18 at 11:20 a.m. The following

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was documented: "Weight: 126.2, date: 6/5/18 at 11:20 a.m."

Review of the dialysis communication form dated 6/18/18 revealed that the weight documented for 6/18/18 was not prior to dialysis. The weight recorded was from 6/7/18 at 1:39 p.m. The following was documented: "Weight 128.6, date 6/7/18 at 139 p.m."

Further review of the June MAR revealed that the resident was documented as being "Absent from home" on the following dialysis days: "6/8/18, 6/11/18, and 6/15/18."

Weights for 6/8/18, 6/11/18, and 6/15/18 could not be found in the clinical record. Further review of the clinical record revealed that Resident #6 was coded as being "Absent from home" because he was at dialysis. Review of the dialysis communication form dated 6/8/18, 6/11/18 and 6/15/18, revealed blanks indicating that the weights were not obtained prior to dialysis.

Further review of the June 2018 MAR revealed a blank or hole for the dialysis day 6/13/18. A weight could not be found in the clinical record. A weight could not be found on the weight log kept at the nursing station. Review of dialysis communication form dated 6/13/18 revealed a blank for weight, indicating that the weight was not obtained prior to dialysis.

Review of the June 2018 MAR revealed the following documented for 6/20/18: "Hold/See Nurse/Note." Review of the nursing notes failed to evidence why his weight was not obtained prior to dialysis.

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On 6/21/18 at 12:00 p.m., an interview was conducted with Resident #6. Resident #6 stated that the facility staff checked his weight about 50 percent of the time.

On 6/21/18 at 12:31 p.m., an interview was conducted with LPN (licensed practical nurse) #2, Resident #6's nurse that shift. When asked what the following order meant: "Weight prior to dialysis on Monday, Wednesday, Friday," LPN #2 stated that weights should be obtained prior to dialysis. When asked if that meant right before the resident leave for dialysis, LPN #2 stated yes, it meant for that day before the resident leaves for dialysis. LPN #2 stated the 11-7 shift completed the dialysis forms in the book but weights were obtained by the day shift. LPN #2 stated that Resident #6 leaves early in the morning for dialysis. LPN #2 stated it appeared nursing was documenting the weight in the dialysis books using a weight from the day before. When LPN #2 was shown the weight recorded for 6/18/18, (dialysis day) was from 6/7/18; LPN #2 stated it appeared daily weights were also not being completed. When asked if this was following the physician's order and comprehensive care plan, LPN #2 stated, it was not. LPN #2 could not determine why some weights were missing from the dialysis book, the vital signs section under PCC and the weight logbook. LPN #2 stated the weight may have been done but not charted. LPN #2 confirmed she had filled out the dialysis communication form on 6/20/18. When asked why she used the weight from 6/19/18 at 3:46 p.m., LPN #6 stated she guessed the order should be clarified because she wasn't sure if the weight had to be right before dialysis or just the most recent weight has to be documented. LPN

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#2 could not recall why she documented "Hold/See nurses note" on the June MAR for 6/20/18. LPN #2 stated she has only worked with Resident #6 for a few days. LPN #2 stated that she was new at the facility.

On 6/22/18 at 8:20 a.m., an interview was conducted with CNA (certified nursing assistant) #1. When asked who was responsible for weighing residents, CNA #1 stated that two aides and one nurse will weight a resident together and the nurse will record the weight. When asked what the following order meant: "Weight prior to dialysis on Monday, Wednesday, Friday," CNA #1 stated a weight should be obtained before the resident leaves for dialysis. CNA #1 stated she did not work with Resident #6, and did not currently have any dialysis patients with that kind of order.

On 6/22/18 at 8:25 a.m., further interview was conducted with LPN #2. When asked what the checks meant on the MAR under a medication and treatment, LPN #2 stated that checks meant a medication was administered or a treatment was provided. When asked if it was ever okay to sign off that a treatment/medication was given when it in fact was not, LPN #2 stated that it was not okay. When asked why nurses were documenting that weights were being completed when they were not, LPN #2 stated she wasn't sure why because she thought a window popped up for the weight to be entered in PCC. LPN #2 stated that she heard that Resident #6 refused weights. When asked about the process followed if a resident refuses weights, LPN #2 stated that the MD (medical doctor) and family has to be notified and a nursing note has to be documented. When asked about the process

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followed if a resident consistently refuses weights, LPN #2 stated that it should be updated on the care plan. LPN #2 stated that it was not on his care plan that he refused weights.

On 6/22/18 at 12:02 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the DON (Director of Nursing), and ASM #4, the Regional Director of Operations, were made aware of the above concerns.

5 b. The facility staff were documenting that Resident #6's daily weights were completed on the June 2018 MAR, when they were not obtained daily.

Review of Resident #6's POS (physician order summary) dated 6/1/18, documented the following order: "Daily Weights- obtain and record- report gain of > (greater) than 3 pounds in 24 hours or < (less than) 5 lbs in one week one time a day for heart failure." This order was initiated on 4/13/18.

Review of June 2018 MAR (medication Administration Record) for Resident #6, revealed check marks, indicating a weight was obtained, on the following days: 6/2/18, 6/4/18, 6/5/18, 6/6/18, 6/7/18, 6/9/18, 6/10/18, 6/12/18, 6/14/18, 6/17/18, 6/18/18, 6/19/18 and 6/21/18.

The daily weight recordings could not be found in the clinical record for to following dates: 6/2/18, 6/4/18, 6/9/18, 6/10/18, 6/12/18, 6/14/18, 6/17/18, and 6/21/18.

Further review of the June 2018 MAR revealed a weight was not obtained on 6/8/18, 6/11/18, and

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6/15/18. The following was documented: "Absent from home." Review of the clinical record revealed Resident #6 was at dialysis on these dates. A weight should have been obtained per another physician's order to check weight prior to dialysis.

The June 2018 MAR also revealed a hole or blank space for 6/13/18. There was no note indicating why a weight was not obtained.

Lastly, the June 2018 MAR documented the following for 6/20/18: "Hold/See nurses note." A note could not be found indicating why this weight was not obtained for this date.

Review of Resident #6's cardiac care plan dated 3/19/18 did not address obtaining daily weights. Resident #6's renal care plan dated 3/19/18 documented the following intervention: "Obtain daily weights as well as prior to dialysis sessions."

On 6/21/18 at 12:00 p.m., an interview was conducted with Resident #6. Resident #6 stated that the facility staff checked his weight about 50 percent of the time.

On 6/21/18 at 12:31 p.m., an interview was conducted with LPN (licensed practical nurse) #2, Resident #6's nurse that shift. LPN #2 stated daily weights were conducted on day shift. LPN #2 stated if weights could not be found in PCC (point click care), they may be in the daily weight book on the unit. This writer checked the daily weight book with LPN #2 for the above dates. Weights for Resident #6 were blank. LPN #2 stated it appeared that daily weights were not being completed. When asked if this was following the physician order and the comprehensive care

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plan, LPN #2 stated, it was not. LPN #2 could not determine why some weights were missing from the vital signs section in PCC and in the weight book. LPN #2 then stated the weights may have been done but not charted. LPN #2 confirmed she was the nurse who worked with Resident #6 on 6/20/18. LPN #2 could not recall why she documented "Hold/See nurses note" on the June MAR for 6/20/18. LPN #2 stated she has only worked with Resident #6 for a few days. LPN #2 stated that she was new to the facility.

On 6/22/18 at 8:20 a.m., an interview was conducted with CNA (certified nursing assistant) #1. When asked who was responsible for weighing residents, CNA #1 stated that two aides and one nurse will weigh a resident together and the nurse will record the weight. CNA #1 stated that she did not work with Resident #6.

On 6/22/18 at 8:25 a.m., further interview was conducted with LPN #2. When asked what the checks meant on the MAR under a medication and treatment, LPN #2 stated that checks meant a medication was administered or a treatment was provided. When asked if it was ever okay to sign off that a treatment/medication was given when it in fact was not, LPN #2 stated that it was not okay. When asked why nurses were documenting that weights were being completed when they were not, LPN #2 stated she wasn't sure why because she thought a window popped up for the weight to be entered in PCC. LPN #2 stated that she heard that Resident #6 refused weights. When asked
the process if a resident refuses weights, LPN #2 stated that the MD and family has to be notified and a nursing note has to be documented. When asked the process if a resident consistently

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refuses weights, LPN #2 stated that it should be updated on the care plan. LPN #2 stated that it was not on his care plan that he refused weights.

On 6/22/18 at 9:20 a.m., an interview was conducted by telephone with LPN #1, a nurse who signed off on the MAR that a daily weight was obtained on 6/9/18 and 6/10/18 for Resident #6. When asked the purpose of monitoring daily weights, LPN #1 stated that the purpose was to monitor for fluid overload. When asked what check marks meant on the MARS/TARS, LPN #1 stated that checks marks meant a medication/treatment was administered. When asked where daily weights were documented, LPN #1 stated daily weights were documented in the clinical record; under the vital sign tab in PCC or in a nursing note. When asked if it was ever okay to document a weight was completed when it was not obtained, LPN #1 stated that it was never okay to document something was done when it was not. When asked why she documented a daily weight was completed for Resident #6 on 6/9/18 and 6/10/18 if a weight was not recorded in the clinical record, LPN #1 stated, "My CNAs get weights for me. I have to go." LPN #1 then hung up the phone.

On 6/22/18 at 12:02 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the DON (Director of Nursing), and ASM #4, the Regional Director of Operations, were made aware of the above concerns. No further information was presented prior to exit.

5 c. The facility staff failed to clarify three as needed physician orders for pain medication for Resident #6.

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Review of Resident #6's June POS (physician order summary) dated 6/1/18, documented the following orders:

"Tylenol (1) 500 mg (milligrams): Give 2 caplets by mouth as needed for pain three times daily. Norco Tablet (2) 7.5 mg/325 mg; Give 1 tablet by mouth every 8 hours as needed for pain. Tramadol (3) HCL (hydrochloride) 50 mg Give 1 tablet every 8 hours as needed for pain."

Review of Resident #6's June 2018 MAR (medication administration record) revealed that he did not receive Tylenol at all that month. Further review of the MAR revealed that he received Norco on the following dates and times:

6/1/18 at 3:02 a.m. for a pain level of 4,
6/2/18 at 9:24 a.m. and 6:17 p.m. for a pain level of 6,
6/3/18 at 5:42 a.m. for a pain level of 8 and 4:10 p.m. for a pain level of 6,
6/4/18 at 1:31 a.m. for a pain level of 4, 9:35 a.m. for a pain level of 6 and 8:44 p.m. for a pain level of 3,
6/5/18 at 5:29 a.m. for a pain level of 4,
6/6/18 at 6:08 a.m. for a pain level of 5 and 5:12 p.m. for a pain level of 6,
6/7/18 at 7:54 a.m. for a pain level of 8 and 5:35 p.m. for a pain level of 2,
6/8/18 at 5:34 a.m. for a pain level of 4,
6/9/18 at 6:01 a.m. for a pain level of 8 and 2:14 p.m. for a pain level of 9,
6/10/18 at 1:12 a.m. for a pain level of 4,
6/11/18 at 5:03 a.m. for a pain level of 2,
6/12/18 at 2:37 a.m. for a pain level of 8,
6/14/18 at 2:30 a.m. for a pain level of 4 and 12:39 p.m. for a pain level of 8,

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6/15/18 at 1:42 a.m. for a pain level of 8 and 3:30 p.m. for a pain level of 5,
6/16/18 at 8:09 a.m. for a pain level of 6 and 10:18 p.m. for a pain level of 5,
6/17/18 at 5:37 a.m. for a pain level of 4, at 12:52 p.m. for a pain level of 4 and 9:01 p.m. for a pain level of 7,
6/18/18 at 4:19 a.m. for a pain level of 4,
6/19/18 at 2:27 a.m. for a pain level of 2,
6/20/18 at 6:06 a.m. for a pain level of 8.

Review of the June 2018 MAR revealed that Resident #6 received Tramadol on the following dates and times:

6/1/18 at 5:57, 6/2/18 at 9:37 p.m., 6/3/18 at 8:56 p.m. and 6/4/18 at 5:35 a.m. all for a pain level of 4,
6/4/18 at 3:35 p.m. for a pain level of 6,
6/5/18 at 2:22 a.m. and 10:45 a.m. for a pain level of 5,
6/9/18 at 9:53 a.m. for a pain level of 8,
6/10/18 at 5:56 a.m. for a pain level of 4,
6/11/18 at 8:54 p.m. for a pain level of 5,
6/13/18 at 5:23 a.m. for a pain level of 2,
6/16/18 at 7:26 p.m. for a pain level of 6,
6/17/18 at 5:36 p.m. for a pain level of 6,
6/18/18 at 1:21 a.m. for a pain level of 4,
6/19/18 at 10:06 a.m. for a pain level of 8,
6/20/18 at 8:10 a.m. for a pain level of 3.

There was no indication specified on when to give each pain medication.

On 6/22/18 at 8:25 a.m., an interview was conducted with LPN (licensed practical nurse) #2, Resident #6's nurse. When asked if a resident has three prn (as needed) orders for pain medication, which one would she give if the order

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does not specify when each medication should be administered, LPN #2 stated that it depended on the resident's pain. When asked about Resident #6's pain medication, LPN #2 stated that Resident #6 decides which pain medication he wants when. When asked why Norco was given for a pain level of 2, LPN #2 stated that the nursing staff should really get clarification from the MD (medical doctor) on when to administer each prn medication. LPN # stated his (Resident #6) orders need to have parameters.

On 6/22/18 at 12:02 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the DON (Director of Nursing), and ASM #4, the Regional Director of Operations, were made aware of the above concerns.

The facility policy titled, "Pain Management Program" did not address the above concerns.

According to "Lippincott Manual Of Nursing Practice", Eighth Edition: by Lippincott Williams & Wilkins, pg. 87 read: "Nursing Alert: Unusual dosages or unfamiliar drugs should always be confirmed with the health care provider and pharmacist before administration." On pg. 15, the following is documented in part, "Inappropriate Orders: 2. Although you cannot automatically follow an order you think is unsafe, you cannot just ignore a medical order, either. b. .. Call the attending physician, discuss your concerns with him, obtain appropriate..orders. c. Notify all involved medical and nursing personnel.... d. Document clearly."

(1) Tylenol Tablet (Acetaminophen) - Treats minor aches and pains and also reduces fever. This information was obtained from The National

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Institutes of Health. https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0008785/?report=details.
(2) Norco (Hydrocodone and acetaminophen) combination is used to relieve moderate to moderately severe pain. Narcotic pain reliever. This information was obtained from The National Institutes of Health. https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0010590/?report=details.
(3) Tramadol is an analgesic used to treat moderate to severe pain. This information was obtained from Davis's Drug Guide for Nurses, 11th edition p. 1197.

6. The facility staff failed to follow professional standards for documenting physician notification of the physician of Resident #74's weight gain of 2 or more pounds in 24 hours or 4 or more pounds in 5 days per physician's order.

Resident #74 was admitted to the facility on 5/24/18 with the diagnoses of but not limited to congestive heart failure, chronic obstructive pulmonary disease, atrial fibrillation, diabetes, left heel pressure ulcer, glaucoma, high blood pressure, chronic kidney disease, and a heart attack. The most recent MDS (Minimum Data Set) was an admission assessment with an ARD (Assessment Reference Date) of 5/31/18. The resident was coded as cognitively intact in ability to make daily life decisions. The resident required total care for bathing; extensive assistance for transfers, dressing, toileting, and hygiene; supervision for eating; and was incontinent of bowel and bladder.

A review of the clinical record revealed an order dated 5/26/18 for "Daily weights in the morning

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for LVAD (left ventricular assist device) management. NOTIFY PHYSICIAN IF WEIGHT GAIN OF 2 or MORE LBS (pounds) IN 24 HOURS OR 4 OR MORE LBS OVER 5 DAYS."

A review of the MAR (Medication Administration Record) revealed that there were no weights obtained on 6/8/18, 6/11/18, 6/17/18, and 6/19/18.

In addition, further review of the MAR revealed the following:
- On 6/1/18, the resident weighed 184.6. On 6/2/18, the resident weighed 186.6. This was a 2-pound weight gain in 24 hours. There was no evidence the physician was notified of the weight gain.

- On 6/7/18, the resident weighed 185.2. There was no weight obtained on 6/8/18. On 6/9/18, the resident weighed 192.6. This was a 7.4-pound weight gain in 2 days. There was no evidence the physician was notified of the missed weight, and of the weight gain.

- On 6/14/18, the resident weighed 189.8. On 6/15/18, the resident weighed 193. This was a 3.2-pound weight gain in 1 day. There was no documented evidence the physician was notified of the weight gain.

- On 6/17/18, and 6/19/18, there were no weights and no evidence the resident refused. However, subsequent weight the following day for each showed a weight loss from the previous weight. There was no documented evidence the physician was notified the weight was not obtained.

There was no evidence in the nurse's notes that

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the physician was notified of any of the above concerns.

On 6/21/18 at 11:12, in an interview with RN #4 (Registered Nurse), when asked what should the nurse do with an order like the one documented above, she stated that the expectation is to notify provider. She stated that if weights are not on the MAR it most likely was not done. RN #4 stated the doctor should have been notified. When asked the importance of following this order, RN #4 stated that if the resident has CHF she is retaining fluid and potentially could have a lot of issues.

On 6/22/18 at 9:36 a.m., in an interview with RN #1, she stated, the nurse is to make sure the resident is weighed and call the doctor if there is a weight gain." RN #1 stated that the nurse should document that the doctor was called. When asked the reason for checking the weights and notifying the doctor, RN #1 stated, "So the doctor can ensure resident is well."

6/22/18 10:55 a.m., in an interview with ASM #3 (Administrative Staff Member, the nurse practitioner), ASM #3 stated that she "feels 99.9% sure I was notified because the nurse is on top of them and calls me every morning about 7:30 (a.m.) to update me. If she is not symptomatic, I am not going to necessarily order something."

A review of the facility policy, "Physician Notification" documented, "Procedure: 1. Notify the physician of a change in the guest's condition. 2. Document the time and date that the physician was notified, the physician's response, and any treatment ordered in the Progress Notes."

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On 6/22/18 at 12:30 p.m., ASM #1 (the Administrator) and ASM #2 (the Director of Nursing) were made aware of the findings.

No further information was provided by the end of the survey.

7. The facility staff failed to clarify the physician's order for Resident #67 for the administration of Lidocaine {1} gel 2% to labia.

Resident #67 was admitted to the facility on 5/7/18 with the diagnoses of but not limited to hematuria, neurogenic bladder, diabetes, muscle spasms, dorsalgia, dementia, high blood pressure, anxiety disorder, and depression. The most recent MDS (Minimum Data Set) was an admission/5-day assessment with an ARD (Assessment Reference Date) of 5/14/18. The resident was coded as being cognitively intact in ability to make daily life decisions. The resident was coded as having an indwelling catheter for bladder function.

A review of the clinical record revealed an order dated 6/3/18 for "Lidocaine {1} gel 2% to labia topically every 4 hours as needed for pain. Apply q4 (every 4 hours) and PRN (as needed)."

A review of the June 2018 MAR (Medication Administration Record) revealed the medication was administered only once, on 6/20/18 at 1:57 a.m.

There was no evidence of an order clarification to administer only PRN, or only every 4 hours scheduled, or as every 4 hours scheduled and as PRN.

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On 6/22/18 at 9:58 a.m., in an interview with RN #1 (Registered Nurse), she stated that if a nurse is confused about an order, they should clarify it, but that her interpretation of the order is that it should be scheduled every four hours and as-needed. In reviewing the MAR with RN #1, she stated based on her interpretation of the order, the MAR is missing a schedule for every 4 hour administration piece, and only reflects the PRN administration piece of the order.

On 6/22/18 at 11:00 a.m., in an interview with ASM #3 (Administrative Staff Member, the nurse practitioner), she stated that the order was intended to be only PRN, and was not intended to be scheduled for every 4 hours.
On 6/22/18 at 12:30 p.m., ASM (administrative staff member) #1 (the Administrator) and ASM #2 (the Director of Nursing) were made aware of the findings. No further information was provided by the end of the survey.

According to "Lippincott Manual Of Nursing Practice", Eighth Edition: by Lippincott Williams & Wilkins, pg. 87 read: "Nursing Alert: Unusual dosages or unfamiliar drugs should always be confirmed with the health care provider and pharmacist before administration." On pg. 15, the following is documented in part, "Inappropriate Orders: 2. Although you cannot automatically follow an order you think is unsafe, you cannot just ignore a medical order, either. b. .. Call the attending physician, discuss your concerns with him, obtain appropriate..orders. c. Notify all involved medical and nursing personnel.... d. Document clearly."

{1} Lidocaine Gel - Lidocaine is a local anesthetic

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(numbing medication). It works by blocking nerve signals in your body. Lidocaine topical (for use on the skin) is used to reduce pain or discomfort caused by skin irritations such as sunburn, insect bites, poison ivy, poison oak, poison sumac, and minor cuts, scratches, or burns. Lidocaine topical is also used to treat rectal discomfort caused by hemorrhoids.
Information obtained from https://www.drugs.com/mtm/lidocaine-topical.html

8. The facility staff failed to clarify the physician's orders for as needed Dilaudid (3) pain medication for Resident #1.

Resident #1 was admitted to the facility on 6/15/18, with diagnoses that included but were not limited to: low back pain, L3-L5 Laminectomy (spine surgery on the lumbar 3-5 vertebra in which damaged bones or disks are removed) (1), heart disease, diabetes, chronic obstructive pulmonary disease (a chronic lung disease that makes it hard to breath) (2), high blood pressure, anxiety, and severe depression.

The most recent MDS (minimum data set) assessment, a five day Medicare assessment, with an assessment reference date of 6/22/18, coded the resident as scoring a "14" on the BIMS (brief interview for mental status) score, indicating that she had no cognitive impairment. She was coded as always understanding others and always making herself understood. Resident #1 was coded as requiring supervision for bed mobility, transfers, toileting, bathing, and personal hygiene.

The physician order dated, 6/19/18, documented, "Dilaudid (an opioid or narcotic pain reliever) (3)

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tablet 2 mg (milligram): give 4 mg by mouth every 6 hours for pain ...Dilaudid tablet 2 mg: give 4 mg by mouth every 3 hours as needed for severe pain." The "as needed" order for Dilaudid failed to document what "severe pain" is or when it should be used based on the resident's pain level.

The June 2018 MAR documented the above physician orders. The "as needed" Dilaudid was documented as having been administered on 6/19/18 at 10:45 p.m. for a pain level of 6.

The baseline care plan, dated 6/15/18, documented in part, "Goal: Guest will be as comfortable as possible." The "Interventions" documented in part, "observe for pain and report to physician as indicated ...Administer pain medications as ordered."

An interview was conducted with RN (registered nurse) #1 on 6/21/18 at 2:35 p.m. When asked how it is determined what "severe pain" is and how she assesses a resident's pain level. RN #1 stated, "We ask them the pain level or to number the pain they are having". When asked how they determine which pain medication to give a cognitively impaired resident, RN #1 stated, "We assess for facial grimacing, restlessness, and any moaning". When asked to define "severe pain" as noted in the above order, RN #1 she stated, "We need to ask the doctor to clarify what severe pain means."

ASM (administrative staff member), #1, the administrator, ASM #2, the director of nursing, ASM #4, the regional director of operations, and ASM #5, the regional clinical coordinator, were made aware of the above concern on 6/22/18 at

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F 658	Continued From page 154 12:02 p.m. According to "Lippincott Manual Of Nursing Practice", Eighth Edition: by Lippincott Williams & Wilkins, pg. 87 read: "Nursing Alert: Unusual dosages or unfamiliar drugs should always be confirmed with the health care provider and pharmacist before administration." On pg. 15, the following is documented in part, "Inappropriate Orders: 2. Although you cannot automatically follow an order you think is unsafe, you cannot just ignore a medical order, either. b. .. Call the attending physician, discuss your concerns with him, obtain appropriate..orders. c. Notify all involved medical and nursing personnel.... d. Document clearly." No further information was provided prior to exit. (1) This information was obtained from the following website: https://medlineplus.gov/ency/article/007389.htm (2) This information was obtained from the following website: https://medlineplus.gov/ency/article/000091.htm (3) This information was obtained from the following website: https://medlineplus.gov/druginfo/meds/a601148.html 9. The facility staff failed to clarify the physician's orders for as needed pain medication for Resident #105. Resident #105 was admitted to the facility on	F 658		

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5/23/18, with diagnoses that included but were not limited to: fractured right shoulder, retention of urine, high blood pressure, muscle weakness, and heart disease.

The most recent MDS (minimum data set) assessment, a 14 day Medicare assessment, with an assessment reference date of 6/4/18, coded the resident as scoring a "13" on the BIMS (brief interview for mental status) score, indicating that she had no cognitive impairment. She was coded as always understanding others and always making herself understood. Resident #105 was coded as requiring extensive assistance of one or more persons for bed mobility, transfers, toileting, bathing, and personal hygiene.

The physician order dated, 5/23/18, documented, "Oxycodone HCl (hydrochloride): Give 2 tablet [sic] by mouth every 6 hours as needed for pain. Give two or one tablet." The "as needed" order for Oxycodone failed to document how staff where to determine whether one or two tablets should be administered or when it should be used based on the resident's pain level.

The June 2018 MAR documented the above physician orders. The "as needed" Oxycodone was documented as having been administered on 6/2/18 at 6:49 p.m. for a pain level of 7; on 6/3/18 at 7:26 p.m. for a pain level of 6; on 6/10/18 at 1:28 a.m. for a pain level of 4; on 6/16/18 at 7:06 p.m. for a pain level of 7 and on 6/17/18 at 1:23 p.m. for a pain level of 6. There was no documentation indicating whether the resident received one or two tablets.

The comprehensive care plan dated 6/2/18,

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F 658	Continued From page 156 documented in part, "Need: Actual pain related to recent fall with fractured right proximal humerus." The "Interventions" documented in part, "Administer medication for pain and observe for effectiveness/side effects and report ineffectiveness to physician ...evaluate characteristics of pain: on scale of 0-10 or verbal description scale: mild, moderate, severe". An interview was conducted with RN (registered nurse) #1 on 6/21/18 at 2:35 p.m. When asked how it is determined how much pain medication is given to a resident when the resident has an order for one or two tablets, RN #1 stated, "We ask them the pain level or to number the pain they are having. That order should not say give two or one, we need to ask the doctor to clarify which level of pain requires which number of tablets." ASM (administrative staff member), #1, the administrator, ASM #2, the director of nursing, ASM #4, the regional director of operations, and ASM #5, the regional clinical coordinator, were made aware of the above concern on 6/22/18 at 12:02 p.m. Fundamentals of Nursing" 8th edition, 2013: Patricia A. Potter and Anne Griffin Perry: Mosby, Inc; Page 983. "Box 43-13 Nursing Principles for Administering Analgesics". No further information was provided prior to exit.	F 658		
F 684 SS=E	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that	F 684		8/3/18

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F 684	Continued From page 157 applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, clinical record review, and facility document review, it was determined that the facility staff failed to ensure residents received treatment and services in accordance with professional standards of practice and the comprehensive person-centered care plan for six of 32 residents in the survey sample; Residents #74, #108, #311, #309, #102, and #6. 1. The facility staff failed to follow physician's orders for obtaining Resident #74's daily weights. 2. The facility staff failed to administer insulin as ordered by the physician for Resident #108. 3a. The facility staff failed to administer medications as ordered by the physician for Resident #311. 3b. The facility staff failed to obtain daily weights as ordered by the physician for Resident #311. 4. The facility staff failed to ensure Resident #309's wound vac (vacuum assisted closure) was in place and functioning per physician's orders. 5. The facility staff failed to document Resident # 102's fluid intake during the day shift on 06/18/18.	F 684	Resident #74 no longer resides in the facility. Resident #108 no longer resides in this facility. Resident #311 is receiving medications and daily weights as order by the Physician. Resident #309s wound vac is in place and functioning as per Physician order. Resident #102s fluid intake is documented as per Physician's order. Resident #6s weights are being obtained and documented as per Physician order. All residents have the potential to be affected. The DON/designee to educate nursing staff on following Physician orders for obtaining and documenting weights, administering medications including insulin as per Physician order, wound care operation and function as per Physician order and documentation of fluid intake. DON/designee during morning clinical meeting to conduct quality monitoring 5x week x1 weeks, weekly x4 and then monthly, PRN and indicated. Findings to be communicated to the QA committee monthly and as indicated. Quality monitoring schedules modified based on findings.	

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6. The facility staff failed to obtain daily weights per physician's order for Resident #6.

The findings include:

1. The facility staff failed to follow physician's orders for obtaining Resident #74's daily weights.

Resident #74 was admitted to the facility on 5/24/18 with the diagnoses of but not limited to congestive heart failure, chronic obstructive pulmonary disease, atrial fibrillation, diabetes, left heel pressure ulcer, glaucoma, high blood pressure, chronic kidney disease, and a heart attack. The most recent MDS (Minimum Data Set) was an admission assessment with an ARD (Assessment Reference Date) of 5/31/18. The resident was coded as cognitively intact in ability to make daily life decisions.

A review of the clinical record revealed an order dated 5/26/18 for "Daily weights in the morning for LVAD (left ventricular assist device) management. NOTIFY PHYSICIAN IF WEIGHT GAIN OF 2 or MORE LBS (pounds) IN 24 HOURS OR 4 OR MORE LBS OVER 5 DAYS."

A review of the MAR (Medication Administration Record) revealed that there were no weights obtained on 6/8/18, 6/11/18, 6/17/18, and 6/19/18.

In addition, further review of the MAR revealed the following:

- On 6/7/18, the resident weighed 185.2. There was no weight obtained on 6/8/18. On 6/9/18, the resident weighed 192.6. This was a 7.4-pound weight gain in 2 days. There was no documented evidence the physician was notified of the weight

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gain and the missed weight.

- On 6/17/18, and 6/19/18, there were no weights and no evidence the resident refused. However, subsequent weight the following day for each showed a weight loss from the previous weight. There was no documented evidence the physician was notified of the missed weights.

On 6/21/18 at 11:12 a.m., in an interview with RN #4 (Registered Nurse), she stated that if weights are not on the MAR (medication administration record) it most likely was not done. When asked the importance of following this order, RN #4 stated if the resident has CHF she is retaining fluid and potentially could have a lot of issues.

On 6/22/18 at 9:36 a.m., in an interview with RN #1, she stated, the nurse is to make sure the resident is weighed and call the doctor if there is a weight gain."

6/22/18 10:55 a.m., in an interview with ASM #3 (Administrative Staff Member, the nurse practitioner), she stated that she "feels 99.9% sure I was notified because the nurse is on top of them and calls me every morning about 7:30 (AM) to update me. If she is not symptomatic, I am not going to necessarily order something."

A review of the care plan revealed one dated 6/3/18 for "Cardiac: At risk for decreased Cardiac Output r/t (related to), HTN (high blood pressure), HLD (hyperlipidemia), A-Fib (atrial fibrillation), CAD (coronary artery disease), CHF (congestive heart failure), Pacemaker...." A review of the interventions included one dated 6/3/18 for "Obtain weight and track changes, report to the physician as needed."

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On 6/22/18 at 12:30 p.m., ASM #1 (the Administrator) and ASM #2 (the Director of Nursing) were made aware of the findings. A facility policy for following physician's orders was requested via a list of policies needed provided to the facility. No further information was provided by the end of the survey.
2. The facility staff failed to administer insulin as ordered by the physician for Resident #108.

Resident #108 was admitted to the facility on 6/7/18 with diagnoses that included but were not limited to: diabetes, depression, high cholesterol, high blood pressure and heart disease.

The most recent MDS (minimum data set) a five day assessment with an ARD (assessment reference date) of 6/14/18 coded the resident as scoring a 15 out of 15 on the brief interview for mental status. Resident #108 was coded as requiring staff assistance for activities of daily living except for eating which the resident could perform independently.

A medication administration observation was made on 6/20/18 at 8:58 a.m. with LPN (licensed practical nurse) #7. LPN #7 took two Humalog insulin pens from the medication cart and set the dose to five units on one pen and eight units on the other pen. LPN #7 then went into Resident #108's room at approximately 9:03 a.m. and administered the insulin in the resident's right and left abdomen. The resident stated he had eaten breakfast around 8:30 a.m.

Review of the care plan initiated on 6/13/18 documented, "Focus: At risk for fluctuation (sic) blood sugars R/T (related to): Diabetes.

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Interventions. Administer medication per order."

Review of the June 2018 physician's orders documented, "HumaLOG (1) kwikPen Solution 100 UNIT/ML (milliliter) Inject 5 unit subcutaneously before meals for diabetes. HumaLOG KwikPen Solution 100 unit/ML inject as per sliding scale: if 141 - 180 = 2u (units); 181 - 220 = 4u; 221 - 260 = 6u; 261 - 300 = 8u; 301 - 350 =10u; 351 - 400 = 14u; 401 - 402 = 14u call md (medical doctor) subcutaneously (below the skin) before meals and at bedtime for dm (diabetes mellitus)."

Review of the June 2018 MAR (medication administration record) documented the above physician's orders. The medication was documented as scheduled for administration to the resident at 7:30 a.m., 11:30 a.m., 5:30 p.m. and 8:00 p.m.

An interview was conducted on 6/21/18 at 12:18 p.m. with LPN #7 and RN (registered nurse) #1, the unit manager. When asked what time frame a medication could be given, LPN #7 stated, "We have some leeway. We're expected to give it right away." When asked when Resident #108's morning insulin was to be given, LPN #7 stated, I think it was 7:30 (a.m.)." When asked if she recalled what time she gave the insulin to Resident #108 on 6/20/18, LPN #7 didn't have a response. When informed the medication had been given a few minutes after nine, LPN #7 did not have a response. When asked if there was any consequence to giving insulin one and a half hours late and after breakfast, LPN #7 stated, "I'm not sure." RN #1 stated, "They can give medication an hour before and an hour after the ordered time." When asked if LPN #7 had

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administered the insulin within the correct timeframe, RN #1 stated she had not.

On 6/22/18 at 12:10 p.m. ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing were made aware of the findings.

No further information was provided prior to exit.

3a. The facility staff failed to administer medications as ordered by the physician for Resident #311.

Resident #311 was admitted to the facility on 6/8/18 with diagnoses that included but were not limited to: infection of the hip, heart failure, irregular heart beat, diabetes, high blood pressure and urinary tract infection.

The most recent MDS (minimum data set) an admission assessment with an ARD (assessment reference date) of 6/15/18 coded the resident as having scored a 12 out of 15 on the brief interview for mental status, indicating the resident was moderately impaired to make daily decisions.

Review of Resident #311's comprehensive care plan initiated on 6/21/18 documented, "Focus. CARDIAC: At risk for decreased Cardiac Output R/T (related to): HTN (hypertension), A-Fib (atrial fibrillation -- an irregular heartbeat), and CHF (congestive heart failure). Interventions. Administer medications as ordered."

Review of the physicians orders dated 6/8/18 documented, "Amiodarone HCL [hydrochloride] (1) Tablet 200 MG (milligrams). Give 1 tablet by

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mouth one time a day for AFIB (atrial fibrillation -- an irregular heartbeat). Start Date: 06/09/2018. Metoprolol Succinate XL (2) Give 100 mg by mouth one time a day for HTN (hypertension). Start Date: 06/09/2018. Keppra (3) Give 500 mg by mouth two times a day for Seizures. Start Date: 06/09/2018. Midrodine (4) 5 mg Give by mouth. Start Date: 06/09/2018. Oxybutynin (5) 2.5 mg give by mouth. Start Date: 06/09/2018. Spironolactone (6) 25 mg Give 1 tablet by mouth one time a day for Heart Failure. Start Date 06/08/2018."

Review of the June 2018 MAR (medication administration record) documented: "Amiodarone HCL Tablet 200 MG (milligrams). Give 1 tablet by mouth one time a day for AFIB (atrial fibrillation -- an irregular heartbeat). Start Date: 06/09/2018." On 6/9/18, a "5" and the nurse's initials were documented.

"Metoprolol Succinate XL. Give 100 mg by mouth one time a day for HTN (hypertension). Start Date: 06/09/2018." On 6/9/18, a "5" and the nurse's initials were documented.

"Keppra Give 500 mg by mouth two times a day for Seizures. Start Date: 06/09/2018." On 6/9/18, a "5" and the nurse's initials were documented at 9:00 a.m. and 5:00 p.m.

"Midrodine 5 mg Give by mouth. Start Date: 06/09/2018." On 6/918 at 9:00 a.m., 1:00 p.m. and 8:00 p.m. and on 6/10/18 at 9:00 a.m. and 1:00 p.m. a "5" and the nurse's initials were documented.

"Oxybutynin 2.5 mg give by mouth. Start Date: 06/09/2018." On 6/9/18 at 9:00 a.m. and 5:00

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p.m. and on 6/10/18 at 9:00 a.m. and 5:00 p.m. a "5" and the nurse's initials were documented.

"Spironolactone 25 mg Give 1 tablet by mouth one time a day for Heart Failure. Start Date 06/08/2018." On 6/9 and 6/10/18 at 9:00 a.m., a "5" and the nurse's initials were documented.

Review of the chart codes on the MAR documented, "5= Hold/See Nurses Notes."

Review of the nurse's notes documented: "6/9/2018 15:10 (3:10 p.m.) eMar (electronic medication administration record) - Medication Administration Note. Amiodarone HCL Tablet 200 MG Give 1 tablet by mouth one time a day for AFIB. Awaiting pharmacy;

6/9/18 15:13 (3:13 p.m.) eMAR - Medication Administration Note. Metoprolol Succinate XL. Give 100 mg by mouth one time a day for HTN. Awaiting pharmacy;

6/9/18 15:13 eMar (electronic medication administration record) - Medication Administration Note. Metoprolol Succinate XL. Give 100 mg by mouth one time a day for HTN. Awaiting pharmacy;

6/9/18 15:13 eMar (electronic medication administration record) - Medication Administration Note. Midrodine 5mg Give by mouth. Awaiting pharmacy;

6/9/18 15:14 eMar (electronic medication administration record) - Medication Administration Note. Oxybutynin 2.5 mg Give by mouth. Awaiting Pharmacy;

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6/9/18 15:14 eMar (electronic medication administration record) - Medication Administration Note. Spironolactone 25 mg Give 1 tablet by mouth one time a day for Heart Failure. Awaiting pharmacy."

An interview was conducted on 6/22/18 at 9:17 a.m. with LPN (licensed practical nurse) #1, the nurse who documented the medications as unavailable. When asked how medications are obtained for new admissions, LPN #1 stated, "So, when I get the admission when the order is put in it (the medications) comes in that night." When asked what staff do if a resident's medications were not available, LPN #1 stated, "I usually call the pharmacy. I can't remember if I called them that night." When asked if anyone else would be notified, LPN #1 stated, "No." When asked if the medications were available in the (name of medication dispensing machine), LPN #1 stated, "I don't know how to take medications out of the machine. I didn't have a PIN and no one else did either."

An interview was conducted on 6/22/18 at 9:19 a.m. with RN (registered nurse) #1, the unit manager. When asked about the process staff follows to obtain medications for a new admission, RN #1 stated, "They verify the orders with the physician. Then they enter them into the computer and the pharmacy delivers them on the next run. When asked how long it would take the pharmacy to deliver the medication, RN #1 stated, "It depends on the admission time. We can pull medications from the (name of mediation dispensing machine) and we have a stat (immediate) box that has IV (intravenous) supplies." When asked how staff accessed the medication-dispensing machine, RN #1 stated,

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"They have a pass code. I heard that if you don't use it in so many days it expires. I know the pharmacy came in and put in new pass codes." When asked if staff were expected to obtain medications available from the medication-dispensing machine, RN#1 stated, "She (LPN #1) should have been able to obtain those medications. If staff can't get them they notify the physician."

A telephone interview was conducted on 6/22/18 at 9:29 a.m. with OSM (other staff member) #2, Pharmacist. When asked about the process for sending medications to the facility, OSM #2 stated, "They are local to us, if its between 7:00 a.m. to 10:00 p.m. and they send an order we send the medication on the next run." When asked if the facility would wait two days for medications, OSM #2 stated they would not.

A telephone interview was conducted on 6/22/18 at 9:32 a.m. with OSM #6, pharmacy customer support. When asked about Resident #311's medications, OSM #6 stated, "They received several medications on 6/8(18). They had some orders that were incomplete and we had to send them a message to get it clarified before we could fill it." The pharmacy manifest was requested at that time.

An interview was conducted on 6/22/18 at 9:53 a.m. with LPN #2. When asked about the process staff follows to obtain medications on new admissions, LPN #2 stated, "We look at the discharge form where they come from, as long as it's signed from the hospital, we enter the medications into the computer I fax it to the pharmacy and then I call them." When asked how long it usually took to obtain medications,

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LPN #2 stated, "It's kinda hard to say. Normally it's six to eight hours. We have a (name of the medication-dispensing machine) and we're able to pull it from there. If it's not in the (medication dispensing machine) I have to call the doctor and see if he wants to change the order or hold it for today and start it the next day."

Review of the pharmacy manifest dated 6/8/18 documented, "Proof of Delivery - Shipment Detail. Date Shipment Summary. (Name of facility). Date Shipped, 6/8/18. Date Received: 6/8/18 10:34 PM. LEVETIRACETAM (Keppra) 1000MG TABLET. QTY (quantity) 8. LEVETIRACETAM F/C 500MG TABLET QTY 4. METOPROLOL SUCCINATE F/C 100 MG. QTY (quantity) 2. AMIODARONE HCL 200MG TABLET. QTY. 2." These medications were documented as not being available from the pharmacy on 6/9/18.

Review of the medication dispensing machine contents log documented, "AMIODARONE HCL 200 MG TABLET. QOH (quantity on hand) 10. METOPROLOL SUCC (succinate) ER (extended release) 50 MG TABLET. QOH 10. LEVETIRACETAM (Keppra) MG. QOH 10. SPIRONOLACTONE 25 MG. QOH 10." These medications were available for administration as ordered by the physician.

On 6/22/18 at 12:10 a.m. ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing were made aware of the findings.

No further information was obtained prior to exit.

1. Amiodarone is a potent arrhythmia suppressing agent that has been clearly linked to several

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distinct forms of drug induced liver disease. This information was obtained from: https://livertox.nih.gov/Amiodarone.htm

2. Metoprolol is a cardioselective beta-blocker that is widely used in the treatment of hypertension and angina pectoris. Metoprolol has been linked to rare cases of drug induced liver injury. This information was obtained from: https://livertox.nih.gov/Metoprolol.htm

3. KEPPRA is indicated as adjunctive therapy in the treatment of partial onset seizures in adults and children 1 month of age and older with epilepsy. This information was obtained from: https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=3ca9df05-a506-4ec8-a4fe-320f1219ab21

4. Midodrine hydrochloride tablets are indicated for the treatment of symptomatic orthostatic hypotension (OH). Because midodrine hydrochloride tablets can cause marked elevation of supine blood pressure (BP>200 mmHg systolic), it should be used in patients whose lives are considerably impaired despite standard clinical care, including non-pharmacologic treatment (such as support stockings), fluid expansion, and lifestyle alterations. This information was obtained from: https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=4c3517f3-1c68-4ade-b5f1-c488a3a335c1

5. Oxybutynin chloride extended-release tablets are a muscarinic antagonist indicated for the treatment of overactive bladder with symptoms of urge urinary incontinence, urgency, and frequency. This information was obtained from:

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https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=033a9242-bbf2-49d5-8403-d07e99107130

6. Spironolactone tablets are indicated for treatment of NYHA Class III-IV heart failure and reduced ejection fraction to increase survival, manage edema, and reduce the need for hospitalization for heart failure. This information was obtained from: https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=beaf74db-4159-3b59-ef99-575c3ac99aa1

3b. The facility staff failed to obtain daily weights on six occasions during June 2018 as ordered by the physician for Resident #311.

Review of the resident's care plan initiated on 6/21/18, documented, "Focus. CARDIAC: At risk for decreased Cardiac Output R/T (related to): HTN (hypertension), A-Fib (atrial fibrillation -- an irregular heartbeat), and CHF (congestive heart failure). Interventions. Obtain weight and track changes. Administer medications as ordered."

Review of the June 2018 physician's orders documented, "daily weight in the morning for chf (congestive heart failure). Start Date: 6/12/18."

Review of the June 2018 TAR (treatment administration record) documented, "daily weight in the morning for chf." Review of the TAR failed to evidence documentation of the resident's weight on 6/12, 6/13, 6/14, 6/15, 6/19 or 6/20/18.

Review of the weight and vital signs summary record did not evidence documentation of the

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resident's weight for the dates documented above.

Review of the nurse's notes for the dates documented above did not evidence documentation regarding the resident's weight for those days.

An interview was conducted on 6/21/18 at 11:57 a.m. with RN (registered nurse) #1, the unit manager. When asked to review the resident's record for the daily weights, RN #1 stated, "Maybe they're in the weight book." RN #1 got the weight book and turned to the resident's name, there was no documentation of weights for the dates documented above. When asked if staff had followed the physician's order, RN #1 stated they had not.

On 6/22/18 at 12:10 p.m. ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing were made aware of the findings.

No further information was provided prior to exit.

4. The facility staff failed to ensure Resident #309's wound vac (vacuum assisted closure) was in place and functioning per physician's orders.

Resident #309 was admitted to the facility on 6/19/18, with diagnoses that included but were not limited to: Right hip replacement with subsequent right hip wound infection requiring hospitalization for antibiotic therapy, heart disease, high blood pressure, a PICC (peripherally inserted central catheter which is a

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long, thin tube that goes into the body through a vein in the upper arm in order to infuse long term medications) (1), and a wound VAC (vacuum assisted closure which is a vacuum pump, a foam piece cut to fit the wound, and a vacuum tube which increases blood flow in the wound and helps with healing.) (2)

The Nursing Comprehensive Evaluation completed on 6/19/18 documented Resident #309 was alert, oriented to person, place and time. It also documented that Resident #309 had clear speech and a calm behavior. An assessment of Resident #309's activities of daily living (ADL) documented that the resident would require the assistance of one person for transfers, bed mobility, toileting and ambulation.

A physician's order with a start date of 6/20/18 documented "Maintain wound VAC setting to right hip @ 125 mmhg (millimeters of mercury) every shift for wound." This order does not have a discontinuation date.

A review of the baseline care plan dated 6/19/18, documented in part, "Treatments as ordered: surgical wound and wound VAC ...observe for S/S (signs and symptoms) of infection and report to physician as indicated".

On 6/20/18 at 11:40 a.m., Resident #309 was observed up in his wheelchair. His wound VAC was observed running at 125 mmhg. It was also noted that the wound VAC was plugged into the wall socket.

On 6/21/18 at 9:00 a.m., Resident #309 was observed in his wheelchair and LPN (licensed practical nurse) #2 was observed handling the

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wound VAC with gloves on. Resident #309 stated, "It [wound VAC] turned off sometime during the night." When was asked about the wound VAC, LPN #2 stated she had just found the wound VAC to off. LPN #2 stated she tried to turn it on but it did not work. She then saw that the wound VAC was no longer plugged into wall socket, so she plugged it in to "charge up" the wound VAC battery. LPN #2 stated she had not heard any alarms and the night shift had not reported any alarms. How long the wound VAC was off was unknown.

An interview was conducted on 6/22/18 at 8:55 a.m. with LPN #9, wound care nurse. When informed of the above observation and interview regarding the wound VAC being off for an unknown period the day before, LPN #9 stated she did not know that, but the wound VAC should always be plugged in overnight to allow it to charge. When asked about the alarms, LPN #9 stated they should make a sound but sometimes "when the charge dies, they just power off." When asked about the potential consequences of the wound VAC not working or not being turned on, LPN #9 stated "it could impact the wound healing process".

ASM (administrative staff member), #1, the administrator, ASM #2, the director of nursing, ASM #4, the regional director of operations, and ASM #5, the regional clinical coordinator, were made aware of the above concern on 6/22/18 at 12:02 p.m.

An interview was conducted on 6/22/18 at approximately 1:15 p.m. with RN (registered nurse) #1. She provided documentation from the wound VAC manufacturer, which stated in part,

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"The most common Alarm conditions are: leak in the system, system clogged, battery discharged and tubing clogged." She stated that the alarms should have sounded. RN #1 confirmed that neither staff nor the resident complained of the alarm going off. She confirmed that the staff had received education regarding the care and servicing of the wound VAC. RN #1 was asked if she could provide a sign in sheet. RN #1 stated she would check for one. She did not provide one prior to exit.

An interview was conducted on 6/22/18 at approximately 3 p.m. with LPN #2 and LPN #3. They both confirmed that they had received training via an in-service on the care and servicing of a wound VAC.

No further information was provided prior to exit.

(1) This information was obtained from the following website: https://medlineplus.gov/ency/patientinstructions/000461.htm

(2) This information was obtained from the following website: https://medlineplus.gov/ency/article/007645.htm

5. The facility staff failed to document Resident # 102's fluid intake during the day shift on 06/18/18.

Resident # 102 was admitted to the facility on 02/10/15 with a readmission of 11/30/17 with diagnoses that included but were not limited to respiratory failure (1) diabetes mellitus (2),

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gastroesophageal reflux disease (3), depressive disorder (4), anxiety (5) and anemia (6).

Resident # 102's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 06/01/18, coded Resident # 102 as scoring a 14 on the brief interview for mental status (BIMS) of a score of 0 - 15, 14 - being cognitively intact for making daily decisions. Resident # 102 was coded as being independent and requiring the assistance of one staff member for activities of daily living.

The physician's orders for Resident # 102 dated 11/30/2017 to 06/30/2018 documented, "1800cc (cubic centimeters)/day. Fluid restriction. Nursing to provide 300 ml (milliliters) on Day shift, 300 ml on Eve (evening) shift, 120 ml on Night shift. Start Date: 05/25/2018."

The eMAR (electronic medication administration record) for Resident # 102 dated June 2018 failed to evidence the amount of fluid Resident # 102 received during the day shift on 06/18/18.

The comprehensive care plan for Resident # 102 dated 03/27/2018 documented, "Need. FLUID: Potential for dehydration related to: Diuretic use, fluid restriction and Dx (diagnoses) of Cirrhosis, HTN (hypertension), DM (diabetes mellitus), thrombocytopenia, metabolic encephalopathy, Gerd, and H/O (history of) irritable bowel. Date initiated: 03/27/2018." Under "Interventions" it documented, "Fluid restrictions as ordered."

On 06/21/18 at 2:20 p.m., an interview was conducted with LPN (licensed practical nurse) # 2. After reviewing the eMAR for Resident # 102 dated June 2018 for the day shift on 06/18/18

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LPN # 2 was asked about the lack of documentation. LPN # 2 stated, "There is no way to tell how much she was given. We would not know if they exceeded the amount if it's not documented." LPN #2 stated, "It could be documented in the nurse's notes, but if it isn't, can't tell how they had. LPN # 2 reviewed the nurse's progress notes for Resident # 102 dated 06/01/18 through 06/18/18. LPN # 2 stated the fluid intake for the day shift on 06/18/18 was not documented. When asked why it was important to document a resident's fluid intake LPN # 2 stated, "If they have too much fluid it could put them into congestive heart failure or throw off their electrolytes."

On 06/22/18 at approximately 12:00 p.m., ASM (administrative staff member) # 1, administrator, ASM # 2, director of nursing were made aware of the above findings.

No further information was provided prior to exit.

References:
(1) A long-term disease. It leads to inflammation of the joints and surrounding tissues. It can also affect other organs. This information was obtained from the website: https://medlineplus.gov/ency/article/000431.htm.

(2) A chronic disease in which the body cannot regulate the amount of sugar in the blood. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/ency/article/001214.htm.

(3) Stomach contents to leak back, or reflux, into the esophagus and irritate it. This information was obtained from the website:

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https://www.nlm.nih.gov/medlineplus/gerd.html.

(4) Depression may be described as feeling sad, blue, unhappy, miserable, or down in the dumps. Most of us feel this way at one time or another for short periods. Clinical depression is a mood disorder in which feelings of sadness, loss, anger, or frustration interfere with everyday life for weeks or more. This information was obtained from the website:
https://medlineplus.gov/ency/article/003213.htm.

(5) Fear. This information was obtained from the website:
https://www.nlm.nih.gov/medlineplus/anxiety.html
#summary.

(6) Low iron. This information was obtained from the website:
https://www.nlm.nih.gov/medlineplus/anemia.html
.
6. The facility staff failed to obtain daily weights per physician's order for Resident #6.

Resident #6 was admitted to the facility on 12/6/17 with diagnoses that included but were not limited to end stage renal disease, heart failure, type two diabetes and COPD (chronic obstructive pulmonary disease). Resident #6's most recent MDS (minimum data set) assessment was a quarterly assessment with an ARD (assessment reference date) of 3/5/18. Resident #6's was coded as being cognitively intact in the ability to make daily decisions scoring 15 out of possible 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #6 was coded as requiring total dependence from one person with walking, and locomotion; and extensive assistance from one person with transfers, bed mobility, dressing,

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toileting, personal hygiene, and bathing.

Review of Resident #6's POS (physician order summary) dated 6/1/18, documented the following order: "Daily Weights- obtain and record- report gain of > (greater) than 3 pounds in 24 hours or < (less than) 5 lbs (pounds) in one week one time a day for heart failure." This order was initiated on 4/13/18.

Review of Resident #6's June 2018 MAR (medication Administration Record) revealed check marks indicating that a weight was obtained for the following days: 6/2/18, 6/4/18, 6/5/18, 6/6/18, 6/7/18, 6/9/18, 6/10/18, 6/12/18, 6/14/18, 6/17/18, 6/18/18, 6/19/18 and 6/21/18.

The daily weight recordings could not be found in the clinical record for: 6/2/18, 6/4/18, 6/9/18, 6/10/18, 6/12/18, 6/14/18, 6/17/18, and 6/21/18.

Further review of the June 2018 MAR revealed that a weight was not obtained on 6/8/18, 6/11/18, and 6/15/18. The following was documented: "Absent from home." Review of the clinical record revealed that Resident #6 was at dialysis on these dates. A weight should have been obtained per another physician's order to check weight prior to dialysis.

The June 2018 MAR also revealed a hole or blank space for 6/13/18. There was no note indicating why a weight was not obtained.

Lastly, the June 2018 MAR documented the following for 6/20/18: "Hold/See nurses note." A note could not be found indicating why this weight was not obtained for this date.

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Review of Resident #6's cardiac care plan dated 3/19/18 did not address obtaining daily weights. Resident #6's renal care plan dated 3/19/18 documented the following intervention: "Obtain daily weights as well as prior to dialysis sessions."

On 6/21/18 at 12:00 p.m., an interview was conducted with Resident #6. Resident #6 stated that the facility staff checked his weight about 50 percent of the time.

On 6/21/18 at 12:31 p.m., an interview was conducted with LPN (licensed practical nurse) #2, Resident #6's nurse that shift. When asked what the following order meant: "Weight prior to dialysis on Monday, Wednesday, Friday," LPN #2 stated that weights should be obtained prior to dialysis. When asked if that meant right before the resident leave for dialysis, LPN #2 stated yes, it meant for that day before the resident leaves for dialysis. LPN #2 stated the 11-7 shift completed the dialysis forms in the book but weights were obtained by the day shift. LPN #2 stated that Resident #6 leaves early in the morning for dialysis. LPN #2 stated it appeared nursing was documenting the weight in the dialysis books using a weight from the day before. When LPN #2 was shown the weight recorded for 6/18/18, (dialysis day) was from 6/7/18; LPN #2 stated it appeared daily weights were also not being completed. When asked if this was following the physician's order and comprehensive care plan, LPN #2 stated, it was not. LPN #2 could not determine why some weights were missing from the dialysis book, the vital signs section under PCC and the weight logbook. LPN #2 stated the weight may have been done but not charted. LPN #2 confirmed she had filled out the dialysis communication form on 6/20/18. When asked

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why she used the weight from 6/19/18 at 3:46 p.m., LPN #6 stated she guessed the order should be clarified because she wasn't sure if the weight had to be right before dialysis or just the most recent weight has to be documented. LPN #2 could not recall why she documented "Hold/See nurses note" on the June MAR for 6/20/18. LPN #2 stated she has only worked with Resident #6 for a few days. LPN #2 stated that she was new at the facility.

On 6/22/18 at 8:20 a.m., an interview was conducted with CNA (certified nursing assistant) #1. When asked who was responsible for weighing residents, CNA #1 stated that two aides and one nurse will weight a resident together and the nurse will record the weight. CNA #1 stated that she did not work with Resident #6.

On 6/22/18 at 8:25 a.m., further interview was conducted with LPN #2. When asked what the checks meant on the MAR under a medication and treatment, LPN #2 stated that checks meant a medication was administered or a treatment was provided. When asked if it was ever okay to sign off that a treatment/medication was given when it in fact was not, LPN #2 stated that it was not okay. When asked why nurses were documenting that weights were being completed when they were not, LPN #2 stated she wasn't sure why because she thought a window popped up for the weight to be entered in PCC. LPN #2 stated that she heard that Resident #6 refused weights. When asked about the process followed if a resident refuses weights, LPN #2 stated that the MD (medical doctor) and family has to be notified and a nursing note has to be documented. When asked about the process followed if a resident consistently refuses

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F 684	Continued From page 180 weights, LPN #2 stated that it should be updated on the care plan. LPN #2 stated that it was not on his care plan that he refused weights. On 6/22/18 at 9:20 a.m., an interview by telephone was conducted with LPN #1, a nurse who signed off on the MAR that a daily weight was obtained on 6/9/18 and 6/10/18 for Resident #6. When asked the purpose of monitoring daily weights, LPN #1 stated that the purpose was to monitor for fluid overload. When asked what check marks meant on the MARS/TARS, LPN #1 stated checks marks meant that a medication/treatment was administered. When asked where daily weights were documented, LPN #1 stated that daily weights were documented in the clinical record; under the vital sign tab either in PCC or in a nursing note. When asked if it was ever okay to document that a weight was completed when it was not obtained, LPN #1 stated that it was never okay to document that something was done when it was not. When asked why she documented a daily weight was completed for Resident #6 on 6/9/18 and 6/10/18 if a weight was not recorded in the clinical record, LPN #1 stated, "My CNAs get weights for me. I have to go." LPN #1 then hung up the phone. On 6/22/18 at 12:02 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the DON (Director of Nursing), and ASM #4, the Regional Director of Operations, were made aware of the above concerns. No further information was presented prior to exit	F 684		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents.	F 689		8/3/18

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F 689	Continued From page 181 The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review and clinical record review, it was determined that facility staff failed to implement assitive devices to prevent accidents and hazards for one of 32 residents in the survey sample, Resident #50. The facility staff failed to implement interventions to prevent injury from falls per plan of care. Multiple observations of Resident #50 during the survey revealed the resident in bed without a fall mat on the floor, as per the comprehensive care plan. The findings include: Resident #50 was admitted to the facility on 1/6/14 and readmitted on 4/13/18 with diagnoses that included but were not limited to type two diabetes, atrial fibrillation, heart failure, and high blood pressure. Resident #50's most recent MDS (minimum data set) assessment was an annual assessment with an ARD (assessment reference date) of 5/7/18. Resident #50 was coded as being cognitively intact in the ability to make daily decisions, scoring 12 out of 15 on the BIMS (Brief Interview for Mental Status) Exam. Resident #50 was coded as requiring extensive assistance with one staff member for bed mobility, toileting, and personal hygiene; and extensive assistance from	F 689	Resident #50s fall mat is in place. All Residents with fall mats have the potential to be affected. The DON/designee to educate nursing staff on following the comprehensive care plan regarding fall mats/fall interventions. DON/designee during morning clinical meeting to conduct quality monitoring 5x week x1 weeks, weekly x4 weeks and then monthly, PRN and indicated. Findings to be communicated to the QA committee monthly and as indicated. Quality monitoring schedules modified based on findings.	

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two plus staff members for transfers.

Review of Resident #50's clinical record revealed that she had a fall on 3/9/18. The following was documented: "Found on floor next to bed on R (right) side at 4:05 p.m. No neuro (neurological) changes noted. Pulse is 124 RR (respirations) is 24 BP (blood pressure) is 134/92. Unable to extend R (right) leg in bed, c/o (complained) pain in hip area. Physician notified and order received to send guest out at 4:10 p.m. Daughter (Name of daughter), notified and requests (Name of hospital). Transported at this time to (Name of hospital) via (Name of EMT [emergency medical transport] Service). "

A fall assessment was completed on 3/6/18 (three days) prior to the fall documenting Resident #50 as being a low risk for falls.

Further review of the clinical record revealed that Resident #50 arrived back to the facility on 3/13/18 with a diagnosis of a right hip fracture.

Review of Resident #50's fall care plan revealed the following intervention was initiated on 3/14/18 on her comprehensive care plan: "Mat to floor next to bed."

Review of Resident #50's admission comprehensive assessment dated 3/13/18, documented Resident #50 as being a low risk for falls. The following Fall intervention was documented as needing to be in place: "Fall Care Plan: Mat to floor next to bed."

On 6/19/18 through 6/22/18 the following observations were made:

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6/19/18 at 6:42 p.m., Resident #50 was lying in bed with her bed up against the right side of wall. There was no fall mat in place to the left side.

6/20/18 at 2:55 p.m., Resident #50 was lying in bed with her bed up against the right side of wall. There was no fall mat in place to the left side.

6/21/18 at 5:00 p.m., Resident #50 was lying in bed with her bed up against the right side of wall. There was no fall mat in place to the left side.

On 5/21/18 at 5:09 p.m., an interview was conducted with CNA (Certified nursing assistant) 2, Resident #50's CNA. When asked how CNAs know what interventions need to be in place for their residents to prevent falls, CNA #2 stated that the CNAs receive verbal report from the nurses. CNA #2 also stated that they could look at their care kardex, which serve as a guide for the aides to follow. When asked if Resident #50 was a fall risk, CNA #2 stated that Resident #50 does not try to get out of bed or her chair unassisted. When asked if Resident #50 needed a fall mat down beside her bed, CNA #2 stated, "No. She hasn't had a fall mat since I've been here." When asked how long CNA #2 had been working at the facility, CNA #2 stated, "A year."

Review of Resident #50 most recent care kardex, did not reveal the intervention for the fall mat.

On 6/21/18 at 5:05 p.m., an interview was conducted with LPN (licensed practical nurse) #3, Resident #50's nurse. When asked if Resident #50 was a fall risk, LPN #3 stated that after her fall on 3/9/18, she thought the resident was at least a low fall risk. When asked if Resident #50 is supposed to have a fall mat in place, LPN #3

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stated she didn't think so. When asked how it is communicated to CNAs residents' needs such as fall prevention interventions, LPN #3 stated nurses verbally communicate with them and give them an update on resident care and the aides also had a care card. When asked the purpose of the comprehensive care plan, LPN #3 stated the purpose was to identify limitations, needs, goals, and serve as a guide for resident care. LPN#3 stated the care plan should be followed unless the care plan was out of date. LPN #3 stated it was important for the care plan to be accurate.

On 6/22/18 at 9:22 a.m., further interview was conducted with LPN#3. LPN #3 confirmed Resident #50's fall mat was on the care plan. LPN #3 stated Resident #50 does not attempt to get out of bed, and the care plan should probably be updated.

On 6/22/18 at 11:19 a.m., an interview was conducted with ASM (administrative staff member) #2, the DON (Director of Nursing). ASM #2 stated she thought the fall mat intervention was an error on the comprehensive care plan because it was not an intervention of the baseline care plan. When asked if the care plan was ever updated, ASM #2 stated that care plans were updated with any changes in condition, on admission and quarterly.

On 6/22/18 at 12:02 p.m., ASM #1, the administrator, ASM #2, the DON (Director of Nursing), and ASM #4, the Regional Director of Operations, were made aware of the above concerns. No further information was presented prior to exit.

The facility policy titled, "Fall Awareness

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F 689	Continued From page 185 Program," did not address the above concerns.	F 689		
F 694 SS=D	Parenteral/IV Fluids CFR(s): 483.25(h) § 483.25(h) Parenteral Fluids. Parenteral fluids must be administered consistent with professional standards of practice and in accordance with physician orders, the comprehensive person-centered care plan, and the resident's goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, facility document review and clinical record review, it was determined that the facility staff failed to provide treatment and services for the care of an intravenous line for one of 32 residents in the survey sample, Resident #311. The facility staff failed to change the intravenous dressing for 12 days instead of the seven days per professional standard after admission for Resident #311. The findings include: Resident #311 was admitted to the facility on 6/8/18 with diagnoses that included but were not limited to: infection of the hip, heart failure, irregular heart beat, diabetes, high blood pressure and urinary tract infection. The most recent MDS (minimum data set) an admission assessment with an ARD (assessment reference date) of 6/15/18 coded the resident as having scored a 12 out of 15 on the brief interview for mental status, indicating the resident was moderately impaired to make daily decisions.	F 694	Resident #311s intravenous dressing is being changed every seven days as per Physician order. All residents with intravenous lines have the potential to be affected. The DON/designee to educate nurses on following Physician orders for changing intravenous dressing every seven days. Don/designee to conduct quality monitoring 5x a week x1 week, weekly x4 and then monthly, PRN and indicated. Findings to be communicated to the QA committee monthly and as indicated. Quality monitoring schedules modified based on findings.	8/3/18

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An observation was made on 6/19/18 at 6:30 p.m. of Resident #311. The resident was awake and alert and sitting up on the side of the bed. The resident's wife was also in the room. The resident had a PICC (a peripherally inserted central catheter (1)) line in his right upper arm, which was covered with a transparent dressing. No date could be seen on the dressing. When asked if the dressing had been changed since he was admitted to the facility, Resident #311 and his wife both said it had not.

Review of the resident's baseline care plan initiated on 6/8/18 documented, "Infection Alert. PICC Line dressing (change) per order."

Review of the June 2018 physician's orders documented, "PICC line dressing change." There was no frequency documented.

Review of the June 2018 MAR (medication administration record) did not evidence a schedule for the PICC line dressing change. In the upper left corner of the MAR was a box labeled Unscheduled "Other" Orders. "PICC line dressing change" was documented in the box.

An interview was conducted on 6/21/18 at 11:35 a.m. with LPN (licensed practical nurse) #2. When asked about the process staff follows when a resident had a PICC line, LPN #2 stated, "So I clean the IV port with alcohol, take my saline syringe, and check for blood flow". When asked when the PICC line dressing was changed, LPN #2 stated, "Our protocol here is every seven days. First I'm going to check his orders." LPN #2 reviewed the resident's order and stated, "It looks like the order was put in on the eighth (6/8/18). It

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says 'PICC line dressing change' so it's not telling me how often to change it." LPN #2 then reviewed the June 2018 MAR and TAR (treatment administration record). LPN #2 stated, "There's nothing there. If the MD (medical doctor) wrote change PICC line dressing, I would clarify the orders to see how often he wants it; some of the doctors want it done every five days or some every seven days." When asked if the resident's PICC line dressing had been changed since admission, LPN #2 stated she did not think it had since there was no schedule and no place to document it.

An interview was conducted on 6/21/18 at 12:40 p.m. with LPN (licensed practical nurse) #8, a nurse who cared for the resident. When asked about the process staff follows when a resident had a PICC line, LPN #8 stated, "When you get them you make sure it's patent (functional). I think the dressing gets changed once a week or as needed." When asked why the dressing was changed, LPN #8 stated, "To avoid infection." When asked if she had changed Resident #311's PICC line dressing since admission, LPN #8 stated, "No."

On 6/22/18 at 12:10 p.m. ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing were made aware of the findings.

Review of the facility's policy titled, "Central Venous Catheter (CVC) Dressing Change" documented, "To Be Performed By: Licensed nurses according to state law and facility policy. The nurse shall be competent in the safe delivery of infusion therapy within her or his scope of practice. The nurse shall be accountable for

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F 694	Continued From page 188 attaining and maintaining competence with infusion therapy within her or his scope of practice. Considerations: 2. The catheter insertion site is a potential entry site for bacteria that may cause a catheter-related infection. Guidance: 1. Sterile dressing change using transparent dressings is performed: 1.1 24 hours post-insertion or upon admission. 1.2 At least weekly. 1.3 If the integrity of the dressing has been compromised (wet, loose or soiled). " No further information was provided prior to exit. PICC line standard -- How to care for the catheter at home -- Dressing change should be done 24 hours after insertion, and every 7 days or when the catheter is soiled or loose. This information was obtained from: https://cc.nih.gov/ccc/patient_education/pepubs/piccsicc.pdf1. PICC -- A device used to draw blood and give treatments, including intravenous fluids, drugs, or blood transfusions. A thin, flexible tube is inserted into a vein in the upper arm and guided (threaded) into a large vein above the right side of the heart called the superior vena cava. A needle is inserted into a port outside the body to draw blood or give fluids. A PICC may stay in place for weeks or months and helps avoid the need for repeated needle sticks. Also called peripherally inserted central catheter. This information was obtained from: https://www.cancer.gov/publications/dictionaries/cancer-terms/def/picc	F 694		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i)	F 695		8/3/18

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F 695	Continued From page 189 § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, clinical record review, and facility document review, it was determined that the facility staff failed to provide respiratory care and services for three of 32 residents in the survey; Residents #74, #94, and #64. 1. The facility staff failed to ensure an order was in place for the administration of oxygen to Resident #74. 2. The facility staff failed to maintain Resident #94's respiratory therapy equipment in a sanitary manner. 3. The facility staff failed to administer Resident # 64's oxygen according to the physician's orders. The findings include: 1. The facility staff failed to ensure an order was in place for the administration of oxygen to Resident #74. Resident #74 was admitted to the facility on 5/24/18 with the diagnoses of but not limited to congestive heart failure, chronic obstructive	F 695	Resident #74 no longer resides in this facility. Resident#94 no longer resides in the facility. Resident #64 oxygen is being administered as per Physician orders. All residents with orders for oxygen/nebulizer treatments have the potential to be affected. The Don/designee to educate Nursing staff on following Physician orders for oxygen and storing respiratory therapy equipment in a sanitary manner. Don/designee to conduct quality monitoring 5x a week x1 week, weekly x4 weeks and then monthly, PRN and indicated. Findings to be communicated to the QA committee monthly and as indicated. Quality monitoring schedules modified based on findings.	

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pulmonary disease, atrial fibrillation, diabetes, left heel pressure ulcer, glaucoma, high blood pressure, chronic kidney disease, and a heart attack. The most recent MDS (Minimum Data Set) was an admission assessment with an ARD (Assessment Reference Date) of 5/31/18. The resident was coded as cognitively intact in ability to make daily life decisions.

Observations made of Resident #74 on 6/20/18 at 9:27 a.m., and 6/20/18 at 2:15 p.m., revealed the oxygen {1} rate on the oxygen concentrator was set at 1.5 liters per minute; and on 6/21/18 at 11:04 a.m., the oxygen concentrator flowrate was set at 2 liters per minute.

A review of the clinical record failed to reveal any current orders for the administration of oxygen.

On 6/21/18 at 11:12 a.m., in an interview with RN #4 (Registered Nurse), she stated that there should be a current order for oxygen. RN #4 stated that she was just checking up on the oxygen order for this resident because she noticed that there was no order for it in the eMAR system (Electronic Medication Administration system). When asked why there should there be an order for oxygen, RN #4 stated that it (oxygen) is technically a medication or treatment and you can give too much oxygen or not enough.

On 6/22/18 at 9:32 a.m., in an interview with RN #1, she stated that there has to be an order for oxygen because it is a medication.

A review of the facility policy, "Nasal Cannula" did not include any direction that the use of oxygen requires a physician's order.

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A review of the facility policy, "Oxygen Concentrators" documented, "2. Turn concentrator on and adjust liter flow (to that ordered by physician)..."

On 6/22/18 at 12:30 p.m., ASM (administrative staff member) #1 (the Administrator) and ASM #2 (the Director of Nursing) were made aware of the findings.

No further information was provided by the end of the survey.

{1} According to Fundamentals of Nursing, Fifth Edition, Lippincott Williams & Wilkins, 2007, page 851, "Because oxygen is a drug, its use requires a prescription....As with all drugs, the potential exists for causing harm with misuse...."

2. The facility staff failed to maintain Resident #94's respiratory therapy equipment in a sanitary manner.

Resident #94 was admitted to the facility on 5/1/18 with the diagnoses of but not limited to sepsis, diabetes, MRSA (Methicillin Resistant Staphylococcus Aureus) infection, surgical aftercare, cellulitis of left lower leg, synovitis and tenosynovitis of left lower leg, osteomyelitis of left ankle and foot, gout, neuropathy, lymphedema, atrial fibrillation, high blood pressure, peripheral venous insufficiency, non-pressure chronic ulcer of ankle and foot, and amputation of left toes. The most recent MDS (Minimum Data Set) was an admission assessment with an ARD (Assessment Reference Date) of 5/8/18. The resident was coded as cognitively intact in ability

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to make daily life decisions.

A review of the clinical record revealed a physician's order dated 5/1/18 for "Ipratropium-Albuterol 0.5-2.5 3mg (milligrams) / 3ml (per 3 milliliters), inhale orally every 4 hours as needed for SOB (shortness of breath) or wheezing, via nebulizer."

A review of the MAR (Medication Administration Record) revealed that the resident was administered the nebulizer treatment on 6/13/18 at 12:39 p.m., and 6/15/18 at 6:25 p.m.

Observations were made of Resident #94 on 6/20/18 at 11:14 a.m., and 6/20/18 at 3:02 p.m., the resident's nebulizer machine was observed on the bedside nightstand. The nebulizer mask was dated 6/13/18 and was not in a bag.

On 6/21/18 at 11:07 a.m., in an interview with RN #4 (Registered Nurse), she stated the nebulizer facemask should be stored in a plastic bag.

On 6/22/18 at 9:32 a.m., in an interview with RN #1, she stated that the nebulizer facemask should be in a plastic bag for infection control reasons.

A review of the facility policy, "Aerosol treatment, Ventilator Dependent" documented, "12. Disassemble nebulizer unit and clean, following policy." There was no further direction for how to store the nebulizer mask for maintaining infection control.

On 6/22/18 at 12:30 p.m., ASM (administrative staff member) #1 (the Administrator) and ASM #2 (the Director of Nursing) were made aware of the findings.

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No further information was provided by the end of the survey.

3. The facility staff failed to administer Resident # 64's oxygen according to the physician's orders.

Resident # 64 was admitted to the facility on 02/14/18 with a readmission of 03/13/18 with diagnoses that included but were not limited to malignant neoplasm (1) of the larynx (2), gastroesophageal reflux disease (3), chronic obstructive pulmonary disease (4), tracheostomy (5) and benign prostatic hyperplasia (6).

Resident # 64's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 05/18/18, coded Resident # 64 as scoring a 14 on the brief interview for mental status (BIMS) of a score of 0 - 15, 14 - being cognitively intact for making daily decisions. Resident # 64 was coded as requiring extensive assistance of one staff member for activities of daily living. Under section "O. Special Treatment, Procedures and Programs" Resident # 64 was coded for "C. Oxygen therapy and E. Tracheostomy care."

An observation on 06/19/18 at approximately, 6:00 p.m., revealed Resident # 64 was in bed receiving oxygen from an oxygen concentrator via a tracheostomy tube. Observation of the flow mete on the O2 (oxygen) concentrator revealed three and a half liter per minute.

An observation on 06/20/18 at 12:45 p.m., revealed Resident # 64, sitting up in bed, watching television, receiving oxygen from an oxygen concentrator via a tracheostomy tube.

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Observation of the flow mete on the O2 (oxygen) concentrator revealed three and a half liter per minute.

An observation on 06/20/18 at 12:53 p.m., revealed a nurse entered resident # 64's room per his request and closed the door. An observation on at 12:54 p.m., revealed Resident # 64, sitting up in bed, watching television, receiving oxygen from an oxygen concentrator via a tracheostomy tube. Observation of the flow mete on the O2 (oxygen) concentrator revealed three and a half liter per minute.

An observation on 06/21/18 at 10:55 a.m., revealed Resident # 64, sitting up in bed, watching television, receiving oxygen from an oxygen concentrator via a tracheostomy tube. Observation of the flow mete on the O2 (oxygen) concentrator revealed three and a half liter per minute.

The physician's orders for Resident # 64 dated 03/03/2018 through 06/30/18 documented, "Oxygen 5 (five) l/min (liters per minute) via trach (tracheostomy) every shift. Order Date: 03/13/2018. Start Date: 03/13/2018."

The EMAR (electronic medication administration record) dated June 2018 for Resident # 64 documented, Oxygen 5 (five) l/min (liters per minute) via trach (tracheostomy) every shift. Start Date: 03/13/2018." Further review of the EMAR documented Resident # 64 received oxygen by tracheostomy on 06/19/18, 06/20/18 and on 06/21/18.

The comprehensive care plan for Resident # 64 dated 03/14/18 documented, "Need. Potential

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difficulty Breathing R/T (related to): SOB (shortness of breath), abnormal respiration, abnormal pulse, oximetry,..R/T cardiac condition, (HTN [hypertension], COPD [chronic obstructive pulmonary disease], Tracheostomy, Cancer, squamous cell cancer of lung). Date initiated: 03/14/2018." Under "Interventions" it documented, "Administer medication & (and) treatment per physician's order. Monitor for effectiveness, side effects and adverse reactions of medications and treatments and report abnormal findings to physician. Oxygen, Pulse Oximetry, Suction, trach (tracheostomy) care, elevate HOB (head of bed)."

On 06/21/18 at 10:55 a.m., an interview was conducted with LPN (licensed practical nurse) # 5. When asked how often a resident's oxygen flow rate is checked LPN # 5 stated, "It's checked every four hours and anytime I go into the resident's room." When asked how the oxygen flow rate, is read on the oxygen concentrator LPN # 5 stated, "The line should pass through the middle of the ball." When asked what the oxygen flow rate for Resident # 64's oxygen concentrator should be, LPN # 5 looked up the physician's order on the EHR (electronic health record) for Resident # 64. LPN # 5 stated, "It should be five liters." LPN # 5 was then asked to read the oxygen flow rate on Resident # 64's oxygen concentrator. LPN # 5 entered Resident # 64's room, walked over to Resident # 64's oxygen concentrator, squatted down in front of the oxygen concentrator to eye level with the flow meter and stated, "It's at four and a half liters but if I stand up and look at it, it reads five liters." When asked to describe the correct position to read the oxygen flow meter, LPN # 5 stated, "I'm not sure, I was never told how to. I'll find out."

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LPN # 5 then turned the knob at the top of the flow meter to increase the oxygen flow rate and stated, "It won't go to five." At 11:15 a.m., LPN # 5 approached this surveyor regarding on how to read the flow meter on the oxygen concentrator. LPN # 5 stated, "You must be at eye level with the ball, his (Resident # 64's) oxygen was at four and a half liters. I also changed out the oxygen concentrator." When asked why it is important to follow the physician's order for the administration of oxygen, LPN # 5 stated, "If it's not given he is not getting enough oxygen as he needs and could cause loss of life or limb."

The "(Name of Oxygen Concentrator) User's Manual" documented, "Flowrate. NOTE: To properly read the flowmeter, locate the prescribed flowrate line n the flowmeter. Next, turn the flow knob until the ball rises to the line. Now, center the ball on the L/min (liter per minute) line prescribed."

The facility's policy "Oxygen Concentrators" documented, "Procedure: 2. Turn concentrator on and adjust the liter flow (to that ordered by the physician). Listen for startup alarm. The black liter flow ball on the gauge should be positioned in the middle of the number line (2.0, 2.5, 3.0. 3.5) prescribed by the physician. 3. Liter flow should be checked by being eye level with the flow meter."

On 06/22/18 at approximately 12:00 p.m., ASM (administrative staff member) # 1, administrator, ASM # 2, director of nursing were made aware of the above findings.

No further information was provided prior to exit.

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References:
(1) The term "malignancy" refers to the presence of cancerous cells that have the ability to spread to other sites in the body (metastasize) or to invade nearby (locally) and destroy tissues. Malignant cells tend to have fast, uncontrolled growth and DO NOT die normally due to changes in their genetic makeup. Malignant cells that are resistant to treatment may return after all detectable traces of them have been removed or destroyed. . This information was obtained from the website: https://medlineplus.gov/ency/article/002253.htm.

(2) The larynx, or voice box, is located in the neck and performs several important functions in the body. The larynx is involved in swallowing, breathing, and voice production. Sound is produced when the air which passes through the vocal cords causes them to vibrate and create sound waves in the pharynx, nose and mouth. The pitch of sound is determined by the amount of tension on the vocal folds. This information was obtained from the website: https://medlineplus.gov/ency/imagepages/19708.htm.

(3) Stomach contents to leak back, or reflux, into the esophagus and irritate it. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/gerd.html.

(4) Disease that makes it difficult to breath that can lead to shortness of breath). This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/copd.html.

(5) A surgical procedure to create an opening through the neck into the trachea (windpipe). A

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F 695	Continued From page 198 tube is most often placed through this opening to provide an airway and to remove secretions from the lungs. This tube is called a tracheostomy tube or trach tube.. This information was obtained from the website: https://medlineplus.gov/ency/article/002955.htm. (6) An enlarged prostate. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/enlargedprostatebph.html.	F 695		
F 697 SS=D	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, facility document review, and clinical record review, it was determined that the facility staff failed to implement a comprehensive pain management program for two of 32 residents in the survey sample, Resident #37, #67, #1, and #105. 1. The facility staff failed to attempt non-pharmacological interventions prior to the use of prn (as needed) pain medication for Resident # 37. 2. The facility staff failed to document the location pain and the effectiveness of pain medication administered to Resident #67 on	F 697	Non-Pharmacological pain interventions are being used for Resident #37. Resident #67s location of pain and effectiveness of pain medication administered is being documented. All residents have the potential to be affected. The DON/designee to educate nursing Staff on using non-pharmacological interventions for pain management as well as educating on documentation of the location of pain and the effectiveness of pain medication administered. DON/designee during morning clinical meeting to conduct quality monitoring 5x week x1week, weekly x4 weeks and then	8/3/18

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F 697	Continued From page 199 multiple occasions during June 2018. The findings include: 1. The facility staff failed to attempt non-pharmacological interventions prior to the use of prn (as needed) pain medication for Resident # 37. Resident # 37 was admitted to the facility on 10/15/17 with a readmission of 04/03/18 with diagnoses that included but were not limited to peripheral vascular disease (1) diabetes mellitus (2), chronic kidney disease (3), depressive disorder (4), anxiety (5) and anemia (6). Resident # 37's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 04/24/18, coded Resident # 37 as scoring a 10 on the brief interview for mental status (BIMS) of a score of 0 - 15, 10 - being moderately impaired of cognition intact for making daily decisions. The physician's orders for Resident # 37 dated 04/01/2018 documented, "Norco (7) Tablet. 7.5-325 MG (milligram) (Hydrocodone-Acetaminophen). Give 1 (one) tablet by mouth every 6 (six) hours as needed for pain max (maximum) daily amount 4 (four) tab (tablets)." The EMAR (electronic medication administration record) for Resident # 37 dated April 2018 documented the above physician's orders. Further review of the EMAR revealed the Norco Tablet. 7.5-325 MG was administered as follows:	F 697	monthly, PRN and indicated. Findings to be communicated to the QA committee monthly and as indicated. Quality monitoring schedules modified based on findings.	

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On 04/06/18 at 9:20 a.m., with a pain level of 4 (four).
On 04/07/18 at 1532 (3:32 p.m.) with a pain level of 9 (nine) and at 2141 (9:41 p.m.) with a pain level of 9 (nine).
On 04/08/18 at 9:10 a.m. with a pain level of 9 (nine), at 1615 (4:16 p.m.) with a pain level of 8 (eight) and at 2232 (10:32 p.m.) with a pain level of 8 (eight).
On 04/09/18 at 2057 (8:57 p.m.) with a pain level of 3 (three).
On 04/13/18 at 1306 (1:06 p.m.) with a pain level of 6 (six).
On 04/14/18 at 11:06 a.m. with a pain level of 6 (six) and at 2017 (8:17 p.m.) with a pain level of 3 (three).
On 04/ 15/18 at 5:12 a.m., with a pain level of 8 (eight).
On 04/16/18 at 5:28 a.m., with a pain level of 7 (seven).
On 04/18 /18 at 2033 (8:33 p.m.) with a pain level of 3 (three).
On 04/21/18 at 8:55 a.m., with a pain level of 4 (four) and at 1714 (5:14 p.m.) with a pain level of 5 (five).
On 04/22/18 at 8:12 a.m., with a pain level of 3 (three) and at 1815 (6:15 p.m.) with a pain level of 8 (eight).
On 04/28/18 at 1:06 a.m., with a pain level of 4 (four).
On 04/30/18 at 1709 (5:09 p.m.) with a pain level of 6 (six).

The EMAR (electronic medication administration record) for Resident # 37 dated May 2018 documented the above physician's order. Further review of the EMAR revealed the Norco Tablet. 7.5-325 MG was administered as follows:
On 05/05/18 at 1806 (6:06 p.m.) with a pain level

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of 4 (four).
On 05/06/18 at 1739 (5:39 p.m.) with a pain level of 5 (five).
On 05 14/18/18 at 9:08 a.m. with a pain level of 6 (six).
On 05/15/18 at10:22 a.m. with a pain level of 5 (five).
On 05/18/18 at 9:08 a.m.) with a pain level of 6 (six).
On 05/19/18 at 1735 (5:53 p.m. with a pain level of 5 (five).
On 05/20/18 at 8:23 a.m. with a pain level of 3 (three) and at 1815 (6:18 p.m.) with a pain level of 6 (six).

The EMAR (electronic medication administration record) for Resident # 37 dated June 2018 documented the above physician's order. Further review of the EMAR revealed the Norco Tablet. 7.5-325 MG was administered on 06/18/18 at 9:25 a.m., with a pain level of 4 (four).

The comprehensive care plan for Resident # 37 dated 04/04/2018 documented, "Need. Potential for pain r/t (related to): AKA (above the knee amputation) and right BKA (below the knee amputation), H/O (history of) CVA (cerebral vascular accident) [stroke], with right hemiparesis, CKD (chronic kidney disease), Diabetes, neuropathy, HTN, hyperlipidemia, CAD (coronary artery disease), anemia, PVD (peripheral vascular disease) Vertigo, Retinopathy. Date initiated: 04/04/2018." Under "Interventions" it documented, "Assist to position for comfort with physical support as necessary. Date initiated: 04/04/2018."

Review of the nurse's progress notes dated 04/06/18 through 06/18/18 failed to evidence

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documentation of non- pharmacological interventions prior to the use of Norco 7.5-325 mg tablet.

On 06/21/18 at approximately 2:20 p.m., an interview was conducted with LPN (licensed practical nurse) # 2. When asked to describe the process for administering PRN (as needed) pain medications LPN # 2 stated, "Ask their (the resident's) pain level using a 0 (zero) to 10 pain scale with 10 being the worse, ask where the pain is located, and describe the pain. Look at the physician's order and see what they have for pain. Before giving the medication I would try non- pharmacological interventions first, recheck the resident's pain and if it was not effective I would give the medication. The non-pharmacological interventions would be documented in the nurse's progress notes." After reviewing the nurse's progress notes for Resident # 37 dated 04/06/18 through 06/18/18, LPN # 2 was asked if non- pharmacological interventions were attempted before the pain medication was administered. LPN # 2 stated there was no documentation of non- pharmacological interventions were attempted.

On 06/22/18 at 10:20 a.m., an interview was conducted with Resident # 37. When asked if the nurse's attempt to relieve his pain by other means before administering his PRN (as needed) pain medication Resident # 37 stated, "They really don't do anything."

On 06/22/18 at approximately 12:00 p.m., ASM (administrative staff member) # 1, administrator, ASM # 2, director of nursing were made aware of the above findings.

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No further information was provided prior to exit.

References:
(1) The vascular system is the body's network of blood vessels. It includes the arteries, veins and capillaries that carry blood to and from the heart. Arteries can become thick and stiff, a problem called atherosclerosis. Blood clots can clog vessels and block blood flow to the heart or brain. Weakened blood vessels can burst, causing bleeding inside the body.) This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/vasculardiseases.html.

(2) A chronic disease in which the body cannot regulate the amount of sugar in the blood. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/ency/article/001214.htm.

(3) Kidneys are damaged and can't filter blood as they should. This information was obtained from the website: https://medlineplus.gov/chronickidneydisease.html.

(4) Depression may be described as feeling sad, blue, unhappy, miserable, or down in the dumps. Most of us feel this way at one time or another for short periods. Clinical depression is a mood disorder in which feelings of sadness, loss, anger, or frustration interfere with everyday life for weeks or more. This information was obtained from the website: https://medlineplus.gov/ency/article/003213.htm.

(5) Fear. This information was obtained from the website:

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https://www.nlm.nih.gov/medlineplus/anxiety.html #summary.

(6) Low iron. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/anemia.html .

(7) Hydrocodone is an opioid pain medication. An opioid is sometimes called a narcotic. Acetaminophen is a less potent pain reliever that increases the effects of hydrocodone. The combination of acetaminophen and hydrocodone is used to relieve moderate to severe pain. This information was obtained from the website: https://www.rxlist.com/norco-5-325-drug/patient-images-side-effects.htm.

2. The facility staff failed to document the location pain and the effectiveness of pain medication administered to Resident #67 on multiple occasions during June 2018.

Resident #67 was admitted to the facility on 5/7/18 with the diagnoses of but not limited to hematuria, neurogenic bladder, diabetes, muscle spasms, dorsalgia, dementia, high blood pressure, anxiety disorder, and depression. The most recent MDS (Minimum Data Set) was an admission/5-day assessment with an ARD (Assessment Reference Date) of 5/14/18. The resident was coded as being cognitively intact in ability to make daily life decisions.

A review of the clinical record revealed an order 6/4/18 for "Oxycodone {1} 10 mg give every 6 hours for moderate to severe pain." There was

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no clarification of what pain levels constituted as "moderate to severe."

A review of the June 2018 MAR revealed the resident received the medication on 6/1/18 (2 times), 6/2/18 (2 times), 6/3/18 (3 times), 6/4/18 (1 time), 6/5/18 (2 times), 6/6/18 (2 times), 6/7/18 (2 times), 6/8/18 (3 times), 6/9/18 (1 time), 6/10/18 (2 times), 6/12/18 (1 time), 6/13/18 (1 time), 6/14/18 (2 times), 6/15/18 (3 times), 6/16/18 (2 times), 6/17/18 (2 times), 6/18/18 (3 times), 6/19/18 (2 times), and 6/20/18 (3 times). This was a total of 39 opportunities. Of these 39 opportunities, the medication was administered for a pain level less than 5 on 7 occasions.

In addition, review of the clinical record revealed that the pain medication was given without documented evidence of the location of the pain on 20 of the 39 opportunities.

Further review of the clinical record revealed that there was no follow up pain scale on 2 of the 39 opportunities and failed to reveal evidence of non-pharmacological interventions being attempted on 31 of the 39 opportunities.

On 6/20/18 at 10:45 a.m., in an interview with Resident #67, she stated that they (the facility) tries other things.

On 6/21/18 at 11:18 a.m., in an interview with RN (registered nurse) #4, regarding pain assessments. RN #4 stated, "vital signs, is the resident alert and oriented, what is their pain level on a 0-10 scale, demeanor, are they responding, crying, tense, what is the location of the pain, attempt non-pharmacological interventions

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depending on what the pain is from and where it is. Try repositioning, ice, etc." When asked if an order states to give for moderate to severe pain, how do staff know what constitutes moderate pain, RN #4 stated moderate pain is classified as anything above a 4. When asked where this classification is documented, RN #4 stated she saw it somewhere. When asked about the process staff follows after pain medication has been given to a resident, RN #4 stated a follow up within an hour to reassess level should occur for effectiveness and a pain level rating. RN #4 stated that all this should be documented.

On 6/22/18 at 9:29 a.m., in an interview with RN #1, she stated that "-3 is mild, 4-6 is moderate, and 7-19 is severe." She stated a resident should not get an oxycodone for a level of 3 because it is considered mild. A facility standard for the correlation of the number scale to "mild, moderate, severe" was requested.

On 6/22/18 at 11:00 a.m., in an interview with ASM #3 (Administrative Staff Member, the nurse practitioner), she stated that "moderate" would be 4 and above. When asked if a nurse can give the Oxycodone for a pain level of "3" then, she stated, that the resident can request it but that legally the nurse can't give it for a level of 3 (if the order states for moderate and moderate is considered 4 or over).

A review of the facility policy, "Pain Management Program" documented, "The Pain Management Program will be used by nursing staff to evaluate, provide appropriate interventions, and monitor the effectiveness of the pain regimen for guests experiencing acute and/or chronic pain, in order to promote comfort and the ability to reach their

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F 697	Continued From page 207 highest functional level....11. The nurse will ask the guest to rate the intensity of the pain with the scale of one (1) to ten (10) with: 0 = No Pain, 5 = Moderate Pain, 10 = Worst Possible Pain. 12....the nurse will document the onset, duration, variations and rhythms, manner of expressing pain, what relieves the pain, and what causes or increases the pain as subjective and objective observations. 13. The nurse will document the effects the pain has on the guest...the nurse will develop a written care plan for pain relief, considering medicinal and non-medicinal interventions..." A review of the care plan revealed one dated 5/18/18 for "Potential for pain r/t (related to) spasms and chronic back pain from multiple back surgeries." The interventions included one, dated 5/18/18, for "Instruct in relaxation techniques as needed and offer comfort measure such as: distraction, back rubs, slow breathing, change of position, etc." On 6/22/18 at 12:30 p.m., ASM (administrative staff member) #1 (the Administrator) and ASM #2 (the Director of Nursing) were made aware of the findings. No further information was provided by the end of the survey. {1} Oxycodone - Oxycodone is used to relieve moderate to severe pain. Information obtained from https://medlineplus.gov/druginfo/meds/a682132.html	F 697		
F 698 SS=D	Dialysis CFR(s): 483.25(l)	F 698		8/3/18

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F 698	Continued From page 208 §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, facility document review, and clinical record review, it was determined that the facility staff failed to provide treatment and services for the care of a dialysis resident, for one of 32 residents in the survey sample, Resident #6. The facility staff failed to obtain Resident #6's weights prior to dialysis per physician's order and plan of care on several occasions in June of 2018. The findings include: Resident #6 was admitted to the facility on 12/6/17 with diagnoses that included but were not limited to end stage renal disease, heart failure, type two diabetes and COPD (chronic obstructive pulmonary disease). Resident #6's most recent MDS (minimum data set) assessment was a quarterly assessment with an ARD (assessment reference date) of 3/5/18. Resident #6's was coded as being cognitively intact in the ability to make daily decisions scoring 15 out of possible 15 on the BIMS (Brief Interview for Mental Status) exam. Review of Resident #6's POS (physician order summary) dated 6/1/18, documented the following orders: "Weight prior to dialysis on Monday, Wednesday, Friday." This order was	F 698	Resident #6s weight is being obtained and documented as per Physician order. All residents have the potential to be affected. The DON/designee to educate nursing staff on obtaining and documenting residents weights as per Physician order. Don/designee during Morning Clinical Meeting to conduct quality monitoring 5x week x1 weeks, weekly x4 weeks and then monthly, PRN and indicated. Findings to be communicated to the QA committee monthly and as indicated. Quality monitoring schedules modified based on findings.	

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initiated on 1/12/18.

"Daily Weights- obtain and record- report gain of > (greater) than 3 pounds in 24 hours or < (less than) 5 lbs (pounds) in one week one time a day for heart failure." This order was initiated on 4/13/18.

Review of Resident #6's Renal Care Plan dated 3/19/18 documented the following intervention: "Obtain daily weights as ordered as well as prior to dialysis sessions."

Review of Resident #6's June 2018 MAR (medication administration record) revealed that Resident #6's had dialysis on the following days:

6/1/18
6/4/18
6/6/18
6/8/18
6/11/18
6/13/18
6/15/18
6/18/18
6/20/18

On 6/1/18, it was documented that Resident #6 had refused his weight.

On 6/4/18, 6/6/18, and 6/18/18; a check mark was documented on the MAR indicating that these weights were obtained prior to dialysis. A weight for 6/4/18 could not be found in the clinical record. A weight for 6/4/18 could not be found on the paper weight log kept at the nursing station. The dialysis communication form for 6/4/18 could not be found in the dialysis book.

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Review of the dialysis communication form dated 6/6/18 revealed that the weight documented for 6/6/18 was not prior to dialysis. The weight was recorded from 6/5/18 at 11:20 a.m. The following was documented: "Weight: 126.2 date: 6/5/18 at 11:20 a.m."

Review of the dialysis communication form dated 6/18/18 revealed that the weight documented for 6/18/18 was not prior to dialysis. The weight recorded was from 6/7/18 at 1:39 p.m. The following was documented: "Weight 128.6, date 6/7/18 at 139 p.m."

Further review of the June MAR revealed that the resident was documented as being "Absent from home" on the following dialysis days: "6/8/18, 6/11/18, and 6/15/18."

Weights for 6/8/18, 6/11/18, and 6/15/18 could not be found in the clinical record. Further review of the clinical record revealed that Resident #6 was coded as being "Absent from home" because he was at dialysis. Review of the dialysis communication form dated 6/8/18, 6/11/18 and 6/15/18, revealed blanks indicating that the weights were not obtained prior to dialysis.

Further review of the June 2018 MAR revealed a blank or hole for the dialysis day 6/13/18. A weight could not be found in the clinical record. A weight could not be found on the weight log kept at the nursing station. Review of dialysis communication form dated 6/13/18 revealed a blank for weight, indicating that the weight was not obtained prior to dialysis.

Review of the June 2018 MAR revealed the

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following documented for 6/20/18: "Hold/See Nurse/Note." Review of the nursing notes failed to evidence why his weight was not obtained prior to dialysis.

On 6/21/18 at 12:00 p.m., an interview was conducted with Resident #6. Resident #6 stated that the facility staff checked his weight about 50 percent of the time.

On 6/21/18 at 12:31 p.m., an interview was conducted with LPN (licensed practical nurse) #2, Resident #6's nurse that shift. When asked what the following order meant: "Weight prior to dialysis on Monday, Wednesday, Friday," LPN #2 stated that weights should be obtained prior to dialysis. When asked if that meant right before the resident leave for dialysis, LPN #2 stated yes, it meant for that day before the resident leaves for dialysis. LPN #2 stated the 11-7 shift completed the dialysis forms in the book but weights were obtained by the day shift. LPN #2 stated that Resident #6 leaves early in the morning for dialysis. LPN #2 stated it appeared nursing was documenting the weight in the dialysis books using a weight from the day before. When LPN #2 was shown the weight recorded for 6/18/18, (dialysis day) was from 6/7/18; LPN #2 stated it appeared daily weights were also not being completed. When asked if this was following the physician's order and comprehensive care plan, LPN #2 stated, it was not. LPN #2 could not determine why some weights were missing from the dialysis book, the vital signs section under PCC and the weight logbook. LPN #2 stated the weight may have been done but not charted. LPN #2 confirmed she had filled out the dialysis communication form on 6/20/18. When asked why she used the weight from 6/19/18 at 3:46

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p.m., LPN #6 stated she guessed the order should be clarified because she wasn't sure if the weight had to be right before dialysis or just the most recent weight has to be documented. LPN #2 could not recall why she documented "Hold/See nurses note" on the June MAR for 6/20/18. LPN #2 stated she has only worked with Resident #6 for a few days. LPN #2 stated that she was new at the facility.

On 6/22/18 at 8:20 a.m., an interview was conducted with CNA (certified nursing assistant) #1. When asked who was responsible for weighing residents, CNA #1 stated that two aides and one nurse will weight a resident together and the nurse will record the weight. When asked what the following order meant: "Weight prior to dialysis on Monday, Wednesday, Friday," CNA #1 stated a weight should be obtained before the resident leaves for dialysis. CNA #1 stated she did not work with Resident #6, and did not currently have any dialysis patients with that kind of order.

On 6/22/18 at 8:25 a.m., further interview was conducted with LPN #2. When asked what the checks meant on the MAR under a medication and treatment, LPN #2 stated that checks meant a medication was administered or a treatment was provided. When asked if it was ever okay to sign off that a treatment/medication was given when it in fact was not, LPN #2 stated that it was not okay. When asked why nurses were documenting that weights were being completed when they were not, LPN #2 stated she wasn't sure why because she thought a window popped up for the weight to be entered in PCC. LPN #2 stated that she heard that Resident #6 refused weights. When asked about the process followed

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F 698	Continued From page 213 if a resident refuses weights, LPN #2 stated that the MD (medical doctor) and family has to be notified and a nursing note has to be documented. When asked about the process followed if a resident consistently refuses weights, LPN #2 stated that it should be updated on the care plan. LPN #2 stated that it was not on his care plan that he refused weights. On 6/22/18 at 12:02 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the DON (Director of Nursing), and ASM #4, the Regional Director of Operations, were made aware of the above concerns. The facility policy titled, "Hemodialysis-Coordination of Services" documents in part the following: "The Facility Dialysis Communication form will be completed by the charge nurse to be sent with the guest to the dialysis center. 3. The Facility Dialysis Communication form may contain the following information: Changes in guest's physical assessment since last exam. Guests mental/emotional state since last dialysis appointment. Oral intake since last appointment. Most recent vital signs. Most recent weight if weighed between treatments. Guests compliance with plan of care. Other appropriate comments." No further information was presented prior to exit.	F 698		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following	F 758		8/3/18

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categories:
(i) Anti-psychotic;
(ii) Anti-depressant;
(iii) Anti-anxiety; and
(iv) Hypnotic

Based on a comprehensive assessment of a resident, the facility must ensure that---

§483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record;

§483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs;

§483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and

§483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order.

§483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be

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F 758	Continued From page 215 renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, and facility document review, it was determined that the facility staff failed to ensure two of 32 residents was free of unnecessary medications, Residents # 32 and # 81. 1. For Resident #32, the facility staff failed to ensure a proper diagnosis for the use of Seroquel [Quetiapine Fumarate] (1). 2. For Resident #81, the facility staff failed to ensure a proper diagnosis for the use of Seroquel. The findings include: 1. For Resident #32, the facility staff failed to ensure a proper diagnosis for the use of Seroquel (1). Resident # 32 was admitted to the facility on 08/12/16 with diagnoses that included but were not limited to Alzheimer's disease (2), anxiety (3), and dysphagia (4). Resident # 32's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 04/19/18, coded Resident # 32 as scoring a 0 (zero) on the brief interview for mental status (BIMS) of a score of 0 - 15, 0 (zero) - being severely impaired of cognition for making daily decisions. Resident # 32 was coded as requiring extensive assistance of one staff member for activities of daily living.	F 758	Resident #32 and #81 have the proper diagnosis for the use of Seroquel. All residents with Physician orders for Seroquel have the potential to be affected. The DON/designee to educate nursing staff/Social Workers on ensuring all residents have the correct diagnosis for psychotropic drug use. Don/designee during Morning Clinical Meeting to conduct quality monitoring 5x week x1 week, weekly x4 weeks and then monthly, PRN and indicated. Findings to be communicated to the QA committee monthly and as indicated. Quality monitoring schedules modified based on findings.	

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The physician's orders dated 01/01/2018 to 06/30/2018 for Resident # 32 documented, "Quetiapine Fumarate 25 MG (milligram) Tablet. Give 0.5 (half tablet) by mouth two times a day for dementia. (5). Start Date: 01/17/2018."

The eMAR (electronic medication administration record) dated June 2018 for Resident # 32 documented, "Quetiapine Fumarate 25 MG Tablet. Give 0.5 by mouth two times a day for dementia. Start Date: 01/17/2018." Further review of the eMAR dated 06/01/18 to 06/21/18 revealed Resident # 32 received Quetiapine Fumarate 41 of 41 opportunities.

On 06/21/18 at 8:52 a.m., an interview was conducted with LPN (licensed practical nurse) # 5. When asked what the indicated use for Seroquel was LPN # 5 stated, "For behaviors" LPN # 5 then reviewed the physician's order on the electronic health record (HER) and stated "She is on it for dementia." When asked if it was the correct diagnosis for the use of Seroquel LPN # 5 stated, "Yes because dementia can cause behaviors."

On 06/21/18, at 8:58 a.m., an interview was conducted with ASM (administrative staff member) # 6, nurse practitioner. When the asked what was the indicated of Seroquel, ASM # 6 stated, "For dementia patient with agitation, for schizophrenia, bipolar and generalized anxiety disorder. When asked if a diagnosis of dementia would be an indicated use for Seroquel, ASM # 6 stated, "No."

On 06/21/18 at 11:25 a.m., a telephone interview was conducted with OSM (other staff member) #

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5, pharmacist. When asked if a diagnosis of dementia was appropriate for the use of Seroquel, OSM # 5 stated, No it is not. It's intended use is on the package label, I'll fax it to you."

On 06/21/18 at approximately 12:50 p.m., the package label for the medication Seroquel was provided to this surveyor. The package label documented, "Quetiapine Tablet." Under "Indications and Usage" it documented, "Schizophrenia, Bipolar Disorder, Special Considerations in Treating Pediatric Schizophrenia and Bipolar Disorder."

On 06/22/18 at approximately 12:00 p.m., ASM (administrative staff member) # 1, administrator, ASM # 2, director of nursing were made aware of the above findings.

No further information was provided prior to exit.

References:
(1) Quetiapine tablets and extended-release (long-acting) tablets are used to treat the symptoms of schizophrenia (a mental illness that causes disturbed or unusual thinking, loss of interest in life, and strong or inappropriate emotions). Quetiapine tablets and extended-release tablets are also used alone or with other medications to treat episodes of mania (frenzied, abnormally excited or irritated mood) or depression in patients with bipolar disorder (manic depressive disorder; a disease that causes episodes of depression, episodes of mania, and other abnormal moods). In addition, quetiapine tablets and extended-release tablets are used with other medications to prevent episodes of mania or depression in patients with

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bipolar disorder. Quetiapine extended-release tablets are also used along with other medications to treat depression. Quetiapine tablets may be used as part of a treatment program to treat bipolar disorder and schizophrenia in children and teenagers. Quetiapine is in a class of medications called atypical antipsychotics. It works by changing the activity of certain natural substances in the brain. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a698019.html.

(2) A brain disorder that seriously affects a person's ability to carry out daily activities). This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/alzheimersdisease.html.

(3) Fear. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/anxiety.html#summary.

(4) A swallowing disorder. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/swallowingdisorders.html.

(5) A loss of brain function that occurs with certain diseases. It affects memory, thinking, language, judgment, and behavior. This information was obtained from the website: https://medlineplus.gov/ency/article/000739.htm.

2. For Resident #81, the facility staff failed to ensure a proper diagnosis for the use of Seroquel (1).

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Resident # 81 was admitted to the facility on 06/24/09 with a readmission of 03/30/11 with diagnoses that included but were not limited to Alzheimer's disease (2) hypertension (3), diabetes mellitus (4), depressive disorder (5), anxiety (6) and anemia (7).

Resident # 81's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 05/23/18, coded Resident # 81 as scoring a 3 (three) on the brief interview for mental status (BIMS) of a score of 0 - 15, 3 (three) - being severely impaired of cognition intact for making daily decisions. Resident # 81 was coded as requiring extensive assistance of one staff member for activities of daily living.

The physician's orders dated 04/01/2018 for Resident # 81 documented, "Seroquel (Quetiapine Fumarate). Give 12.5 mg (milligram) by mouth two times a day for mood disorder. Start Date: 06/15/2018."

The eMAR (electronic medication administration record) dated June 2018 for Resident # 81 documented, "Seroquel (Quetiapine Fumarate). Give 12.5 mg by mouth two times a day for mood disorder. Start Date: 06/15/2018." Further review of the eMAR dated 06/15/18 to 06/20/18 revealed Resident # 81 received Quetiapine Fumarate nine of nine opportunities.

On 06/21/18 at 8:52 a.m., an interview was conducted with LPN (licensed practical nurse) # 5. When asked what the indicated use for Seroquel was LPN # 5 stated, "For behaviors" LPN # 5 then reviewed the physician's order on the electronic health record (HER) and stated

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"She is on it for dementia." When asked if it was the correct diagnosis for the use of Seroquel LPN # 5 stated, "Yes because dementia can cause behaviors."

On 06/21/18, at 8:58 a.m., an interview was conducted with ASM (administrative staff member) # 6, nurse practitioner. When the asked what was the indicated of Seroquel, ASM # 6 stated, "For dementia patient with agitation, for schizophrenia, bipolar and generalized anxiety disorder. When asked if a diagnosis of dementia would be an indicated use for Seroquel, ASM # 6 stated, "No."

On 06/21/18 at 11:25 a.m., a telephone interview was conducted with OSM (other staff member) # 5, pharmacist. When asked if a diagnosis of dementia was appropriate for the use of Seroquel, OSM # 5 stated, No it is not. It's intended use is on the package label, I'll fax it to you."

On 06/21/18 at approximately 12:50 p.m., the package label for the medication Seroquel was provided to this surveyor. The package label documented, "Quetiapine Tablet." Under "Indications and Usage" it documented, "Schizophrenia, Bipolar Disorder, Special Considerations in Treating Pediatric Schizophrenia and Bipolar Disorder."

On 06/22/18 at approximately 12:00 p.m., ASM (administrative staff member) # 1, administrator, ASM # 2, director of nursing were made aware of the above findings.

No further information was provided prior to exit.

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References:
(1) Quetiapine tablets and extended-release (long-acting) tablets are used to treat the symptoms of schizophrenia (a mental illness that causes disturbed or unusual thinking, loss of interest in life, and strong or inappropriate emotions). Quetiapine tablets and extended-release tablets are also used alone or with other medications to treat episodes of mania (frenzied, abnormally excited or irritated mood) or depression in patients with bipolar disorder (manic depressive disorder; a disease that causes episodes of depression, episodes of mania, and other abnormal moods). In addition, quetiapine tablets and extended-release tablets are used with other medications to prevent episodes of mania or depression in patients with bipolar disorder. Quetiapine extended-release tablets are also used along with other medications to treat depression. Quetiapine tablets may be used as part of a treatment program to treat bipolar disorder and schizophrenia in children and teenagers. Quetiapine is in a class of medications called atypical antipsychotics. It works by changing the activity of certain natural substances in the brain. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a698019.html.

(2) A brain disorder that seriously affects a person's ability to carry out daily activities) This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/alzheimersdisease.html.

(3) High blood pressure. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/highbloodpr

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F 758	Continued From page 222 essure.html. (4) A chronic disease in which the body cannot regulate the amount of sugar in the blood. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/ency/article/001214.htm. (5) Depression may be described as feeling sad, blue, unhappy, miserable, or down in the dumps. Most of us feel this way at one time or another for short periods. Clinical depression is a mood disorder in which feelings of sadness, loss, anger, or frustration interfere with everyday life for weeks or more. This information was obtained from the website: https://medlineplus.gov/ency/article/003213.htm. (6) Fear. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/anxiety.html#summary. (7) Low iron. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/anemia.html .	F 758		
F 842 SS=E	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted	F 842		8/3/18

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to do so.

§483.70(i) Medical records.
§483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are-
(i) Complete;
(ii) Accurately documented;
(iii) Readily accessible; and
(iv) Systematically organized

§483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is-
(i) To the individual, or their resident representative where permitted by applicable law;
(ii) Required by Law;
(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;
(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.

§483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.

§483.70(i)(4) Medical records must be retained for-
(i) The period of time required by State law; or

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F 842	Continued From page 224 (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined that the facility staff failed to maintain a complete and accurate medical record for four of 32 residents in the survey sample, Resident #22, 308, 102 and 6. 1. The facility staff failed to document the placement of the scopolamine patch was checked as directed on the medication administration record on 7 occasions in June 2018, for Resident #22. 2. The facility staff failed to ensure that a care plan intended for another resident was not included on the care plan for Resident #308. 3. The facility staff failed to document the administration of scheduled medications for Resident # 102.	F 842	Resident #22 scopolamine patch is in place and documented on the resident's medical record. Resident #308 has been corrected. Resident #102s medications are being documented on the medical record. Catheter care is being completed and documented on Resident #6. All residents have the potential to be affected. DON/designee to educate nursing staff on following Physician orders for medication administration and documentation as well as catheter care and documentation in the medical record. DON/designee during morning clinical meeting to conduct quality monitoring 5x week x1 week, weekly x4 weeks and then monthly, PRN and indicated. Findings to be communicated to the QA	

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F 842	Continued From page 225 4. The facility staff failed to document that catheter care was completed for Resident #6 on several occasions in June of 2018. The findings include: 1. Resident #22 was admitted to the facility on 2/23/17 with diagnoses that included but not limited to: multiple sclerosis (1), high blood pressure, depression, dementia, low back pain, stroke and insomnia. Review of the most recent MDS (minimum data set), an annual assessment, with an ARD (assessment reference date) of 4/3/18, coded the resident as having scored a 13 out of 15 on the BIMS Brief interview for mental status) indicating the resident was cognitively intact to make daily decisions. . Review of the July 2018 physician's orders documented, "SCOPOLAMINE (1) 1MG (milligrams)/3DAY PATCH Apply 1 patch transdermally one time a day every 3 day(s) for increased secreations (sic) and remove per schedule." It was documented that the patch had been applied every three days. Review of the July 2018 MAR (medication administration record) documented, "SCOPOLAMINE (1) 1MG (milligrams)/3DAY PATCH Apply 1 patch transdermally one time a day every 3 day(s) for increased secreations (sic) and remove per schedule." It was documented that the patch had been applied every three days. Further review of the MAR documented, "Check placement of Scopolamine Patch every shift." There was no evidence of documentation that the patch had been checked on 7 occasions as	F 842	committee monthly and as indicated. Quality monitoring schedules modified based on findings.	

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evidenced by blank spaces on the MAR.

An interview was conducted on 6/21/18 at 12:40 p.m. with LPN (licensed practical nurse) #8, the resident's nurse. When asked what a blank space on the MAR meant, LPN #8 stated that it could be that it was not documented or not done. When asked to review Resident #22's MAR for the scopolamine patch, LPN #8 stated she probably just didn't document it.

An interview was conducted on 6/22/18 at 2:01 p.m. with LPN #3. When asked what blank spaces on the MAR meant, LPN #3 stated, "Looking at it, looks like it was never done or they forgot to document it." When asked if it was important to have an accurate clinical record, LPN #3 stated, yes because it was a way for staff to know how the resident was doing.

On 6/22/18 at 12:10 p.m. ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing were made aware of the findings. A request was made for a policy on complete and accurate medical records from ASM #2 at that time.

On 6/22/18 at 2:35 p.m. ASM #5, the director of nursing from an affiliated facility stated, "We don't have a policy on complete and accurate medical record."

No further information was provided prior to exit.

1. Scopolamine -- Scopolamine is an alkaloid from SOLANACEAE, especially DATURA and SCOPOLIA. Scopolamine and its quaternary derivatives act as antimuscarinics like ATROPINE, but may have more central nervous

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system effects. Among the many uses are as an anesthetic premedication, in URINARY INCONTINENCE, in MOTION SICKNESS, as an antispasmodic, and as a mydriatic and cycloplegic. This information was obtained from: https://pubchem.ncbi.nlm.nih.gov/compound/scopolamine#section=Top

2. The facility staff failed to ensure that a care plan intended for another resident was not included on the care plan for Resident #308.

Resident #308 was admitted to the facility on 6/6/18 with diagnoses that included but were not limited to: irregular heart beat, diabetes, heart failure, high blood pressure and obesity.

The most recent MDS (minimum data set), an admission assessment, with an ARD (assessment reference date) of 7/13/18 coded the resident as having scored a 14 out of 15 on the brief interview for mental status (BIMS) indicating the resident was cognitively intact to make daily decisions. The resident was coded as requiring assistance from staff for all activities of daily living with the exception of eating which the resident could perform after the tray was prepared.

Review of the resident's care plan initiated on 6/6/18 and revised on 6/1/18 documented, "Need. ADL (activities of daily living) PREF (preference): Requires 1-2 person assistance with ADLs...Interventions. Abdominal Binder to protect PEG (1) tube.

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Review of the June 2018 physician's orders did not evidence documentation regarding a PEG tube.

Review of the June 2018 MAR did not evidence documentation regarding a PEG tube.

An interview was conducted on 6/21/18 at 11:35 a.m. with LPN (licensed practical nurse) #2, the resident's nurse and RN (registered nurse) #1, the unit manager. When asked if the resident had a PEG tube, LPN #2 stated, "No." When asked to review the above care plan, LPN #2 stated, "That was put in wrong." RN #1 stated, "That was supposed to be for (named a different resident), I put that in wrong." When asked why it was important for the care plan to be accurate, RN #1 stated it guided the plan of care for the resident.

On 6/22/18 at 12:10 p.m. ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing were made aware of the findings.

No further information was obtained prior to exit.

1. PEG -- Percutaneous endoscopic gastrostomy (PEG) is the preferred route of feeding and nutritional support in patients with a functional gastrointestinal system who require long-term enteral nutrition. Besides its well-known advantages over parenteral nutrition, PEG offers superior access to the gastrointestinal system over surgical methods. This information was obtained from: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4069302/
3. The facility staff failed to document the

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administration of scheduled medications for Resident # 102.

Resident # 102 was admitted to the facility on 02/10/15 with a readmission of 11/30/17 with diagnoses that included but were not limited to respiratory failure (1) diabetes mellitus (2), gastroesophageal reflux disease (3), depressive disorder (4), anxiety (5) and anemia (6).

Resident # 102's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 06/01/18, coded Resident # 102 as scoring a 14 on the brief interview for mental status (BIMS) of a score of 0 - 15, 14 - being cognitively intact for making daily decisions. Resident # 102 was coded as being independent and requiring the assistance of one staff member for activities of daily living.

The eMAR (electronic medication administration record) for Resident # 102 dated June 2018 failed to evidence the following medications were administered to Resident # 102
Prednisone* (treats inflammation) on 06/10/18.
Spiriva* (used for asthma) on 06/10/18.
Augmentin* (for pneumonia) on 06/10/18.
Buspirone* (for anxiety) on 06/10/18.
Dicyclomine* (for irritable bowel syndrome) on 06/10/18.
Ferrous Sulfate* (for low iron) on 06/10/18.
Florastor* (probiotic) on 06/10/18.
Lantus* (insulin) on 06/10/18.
Spironolactone* (for edema) on 06/10/18.
Albuterol* (for asthma) on 06/09/18 and 06/10/18.
Enulose Solution* (for high ammonia levels) on 06/09/18 and 06/10/18.
*Information was obtained from medline plus. https://medlineplus.gov/

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On 06/22/18 at 8:00 a.m., an interview was conducted with RN (registered nurse) # 2. After reviewing the EMAR dated June 2018 for Resident # 102 and the blanks during the 7:00 a.m. to 3:00 p.m., shift on 06/09/18 and 06/10/18, RN # 2 was what the blanks indicated. RN # 2 stated, "It appears the nurse didn't document the medication was given."

On 06/22/18 at 8:30 a.m., a telephone interview was conducted with LPN (licensed practical nurse) # 5 regarding her lack documentation on the EMAR for Resident # 102's medication administration on 06/09/18 and 06/10/18. LPN # 5 stated she did work on the 7:00 a.m. to 3:00 p.m., shift on 06/09/18 and 06/10/18. When asked about the blanks left on the EMAR during the 7:00 a.m. to 3:00 p.m., shift on 06/09/18 and 06/10/18, LPN # 5 stated, "They were given, the system must not have recorded it."

On 06/22/18 at approximately 12:00 p.m., ASM (administrative staff member) # 1, administrator, ASM # 2, director of nursing were made aware of the above findings.

No further information was provided prior to exit.

References:
(1) A long-term disease. It leads to inflammation of the joints and surrounding tissues. It can also affect other organs. This information was obtained from the website: https://medlineplus.gov/ency/article/000431.htm.

(2) A chronic disease in which the body cannot regulate the amount of sugar in the blood. This information was obtained from the website:

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https://www.nlm.nih.gov/medlineplus/ency/article/001214.htm.

(3) Stomach contents to leak back, or reflux, into the esophagus and irritate it. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/gerd.html.

(4) Depression may be described as feeling sad, blue, unhappy, miserable, or down in the dumps. Most of us feel this way at one time or another for short periods. Clinical depression is a mood disorder in which feelings of sadness, loss, anger, or frustration interfere with everyday life for weeks or more. This information was obtained from the website: https://medlineplus.gov/ency/article/003213.htm.

(5) Fear. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/anxiety.html#summary.

(6) Low iron. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/anemia.html.

4. The facility staff failed to document that catheter care was completed for Resident #6 on several occasions in June of 2018.

Resident #6 was admitted to the facility on 12/6/17 with diagnoses that included but were not limited to end stage renal disease, heart failure, type two diabetes and COPD (chronic obstructive pulmonary disease). Resident #6's most recent MDS (minimum data set) assessment was a quarterly assessment with an ARD (assessment reference date) of 3/5/18. Resident #6's was

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coded as being cognitively intact in the ability to make daily decisions scoring 15 out of possible 15 on the BIMS (Brief Interview for Mental Status) exam.

Review of Resident #6's June POS (physician order summary) documented the following order: "Foley catheter 18 F (French), 10 cc balloon. With cath (catheter) care every shift."

Review of Resident #6's June 2018 TAR (treatment administration record) revealed holes (blank spaces) for the following dates and times:

6/1/18 night shift,
6/6/18 day shift,
6/10/18 night shift,
6/12/18 night shift,
6/18/18 night shift.

On 6/21/18 at 12:00 p.m., an interview was conducted with Resident #6. Resident #6 stated that the staff did his catheter care every shift.

On 6/22/18 at 8:25 a.m., an interview was conducted with LPN (licensed practical nurse) #2, Resident #6's nurse. When asked who was responsible for providing catheter care, LPN #2 stated that nurses were responsible for providing care every shift. LPN #2 stated that catheter care provided should be documented on the TAR (treatment administration record). When asked what blanks meant on the TAR, LPN #2 stated that it meant that the nurse forgot to sign or that the treatment was not provided. LPN #2 stated that it should be documented because it is a physician's order.

On 6/22/18 at 12:02 p.m., ASM (administrative

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F 842	Continued From page 233 staff member) #1, the administrator, ASM #2, the DON (Director of Nursing), and ASM #4, the Regional Director of Operations, were made aware of the above concerns. Potter and Perry's Fundamentals of Nursing (6th edition) pg.482 states, "(Clinical) Records need to reflect accountability during the time frame of the entry ...The entry needs to clearly show what was done, when it was done, and by whom...Most health care agencies use military time."	F 842		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and	F 880		8/3/18

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procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and
(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.

§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.

§483.80(e) Linens.
Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.

§483.80(f) Annual review.
The facility will conduct an annual review of its

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	495394	A. BUILDING _____ B. WING _____	C 06/22/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LAURELS OF BON AIR	9101 BON AIR CROSSINGS DRIVE BON AIR, VA 23235

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 235 IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review and clinical record review, it was determined that the facility staff failed to maintain infection control practices for one of 32 resident in the survey sample, Resident # 64. The facility staff failed to wash their hands after changing gloves during Resident # 64's tracheostomy care. The findings include: Resident # 64 was admitted to the facility on 02/14/18 with a readmission of 03/13/18 with diagnoses that included but were not limited to malignant neoplasm (1) of the larynx (2), gastroesophageal reflux disease (3), chronic obstructive pulmonary disease (4), tracheostomy (5) and benign prostatic hyperplasia (6). Resident # 64's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 05/18/18, coded Resident # 64 as scoring a 14 on the brief interview for mental status (BIMS) of a score of 0 - 15, 14 - being cognitively intact for making daily decisions. Resident # 64 was coded as requiring extensive assistance of one staff member for activities of daily living. Under section "O. Special Treatment, Procedures and Programs" Resident # 64 was coded for "C. Oxygen therapy and E. Tracheostomy care." On 06/22/18 at approximately 7:30 a.m., an observation was conducted of LPN (licensed practical nurse) # 6 providing Resident # 64's	F 880	The facility staff are washing their hands after changing gloves during resident #64s tracheostomy care. All residents have the potential to be affected. DON/ designee to re-educate nurses on infection control including handwashing. DON/designee to conduct quality monitoring 5x week x1 week, weekly x4 weeks and then monthly, PRN and indicated. Findings to be communicated to the QA committee monthly and as indicated. Quality monitoring schedules modified based on findings.	

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tracheostomy care. LPN # 6 initially washed her hands, donned a pair of gloves, gathered two "Tracheostomy Cleaning Kits" and placed them on an over-the-bed table with a clean barrier. LPN # 6 remover her gloves, placed them into the trash can, opened one of the "Tracheostomy Cleaning Kits", removed the pair of sterile gloves and put then on, loosened the tracheostomy collar, removed the cannula, and placed it in the cleaning tray containing the cleaning solution. LPN #6 then cleaned the cannula and around the opening in Resident # 64's throat. LPN #6 then removed the sterile gloves, opened the other tracheostomy cleaning kit, removed the pair of sterile gloves and put then on, replaced the clean cannula and reattached the collar, picked up the supplies, placed them in the trash, removed her gloves and washed her hands.

On 06/22/18 at approximately 7:40 a.m., an interview was conducted with LPN # 6. When asked to describe the procedure followed when changing gloves LPN # 6 stated, "Wash your hands each time you change your gloves. I know I didn't do that."

The facility's policy "Using Gloves" documented, "4. Wash hands after removing gloves. Gloves do not replace hand washing."

On 06/22/18 at approximately 12:00 p.m., ASM (administrative staff member) # 1, administrator, ASM # 2, director of nursing were made aware of the above findings.

No further information was provided prior to exit.

References:
(1) The term "malignancy" refers to the presence

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of cancerous cells that have the ability to spread to other sites in the body (metastasize) or to invade nearby (locally) and destroy tissues. Malignant cells tend to have fast, uncontrolled growth and DO NOT die normally due to changes in their genetic makeup. Malignant cells that are resistant to treatment may return after all detectable traces of them have been removed or destroyed. . This information was obtained from the website: https://medlineplus.gov/ency/article/002253.htm.

(2) The larynx, or voice box, is located in the neck and performs several important functions in the body. The larynx is involved in swallowing, breathing, and voice production. Sound is produced when the air which passes through the vocal cords causes them to vibrate and create sound waves in the pharynx, nose and mouth. The pitch of sound is determined by the amount of tension on the vocal folds. This information was obtained from the website: https://medlineplus.gov/ency/imagepages/19708.htm.

(3) Stomach contents to leak back, or reflux, into the esophagus and irritate it. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/gerd.html.

(4) Disease that makes it difficult to breath that can lead to shortness of breath). This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/copd.html.

(5) A surgical procedure to create an opening through the neck into the trachea (windpipe). A tube is most often placed through this opening to provide an airway and to remove secretions from

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F 880	Continued From page 238 the lungs. This tube is called a tracheostomy tube or trach tube.. This information was obtained from the website: https://medlineplus.gov/ency/article/002955.htm. (6) An enlarged prostate. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/enlargedprostatebph.html.	F 880		